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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

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IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
February 1, 2019	**March 1, 2019**	March 31, 2019	April 30, 2019
February 15, 2019	**March 15, 2019**	March 31, 2019	April 30, 2019
March 1, 2019	**April 1, 2019**	April 30, 2019	May 30, 2019
March 15, 2019	**April 15, 2019**	April 30, 2019	May 30, 2019
April 1, 2019	**May 1, 2019**	May 31, 2019	June 30, 2019
April 15, 2019	**May 15, 2019**	May 31, 2019	June 30, 2019
May 1, 2019	**June 3, 2019**	June 30, 2019	July 30, 2019
May 15, 2019	**June 17, 2019**	June 30, 2019	July 30, 2019
June 3, 2019	**July 1, 2019**	July 31, 2019	August 30, 2019
June 17, 2019	**July 15, 2019**	July 31, 2019	August 30, 2019
July 1, 2019	**August 1, 2019**	August 31, 2019	September 30, 2019
July 15, 2019	**August 15, 2019**	August 31, 2019	September 30, 2019
August 1, 2019	**September 2, 2019**	September 30, 2019	October 30, 2019
August 15, 2019	**September 16, 2019**	September 30, 2019	October 30, 2019

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at www.sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	*Code of State Regulations*	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is www.sos.mo.gov/adrules/csr/csr

The *Register* address is www.sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2016. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Department of Social Services, MO HealthNet Division under section 536.025, RSMo, the division hereby terminates an emergency amendment effective May 31, 2019.

13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the ***Missouri Register*** on February 1, 2019 (44 MoReg 494-496).

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates. The division is adding paragraph (3)(A)23.

PURPOSE: This amendment provides for a per diem increase to nursing facility and HIV nursing facility per diem reimbursement rates of one dollar and twenty-nine cents ($1.29) effective for dates of service February 1, 2019 through June 30, 2019. The per diem increase shall be reduced to fifty-four cents ($0.54) effective for dates of service beginning July 1, 2019. These per diem adjustments correspond to the state fiscal year (SFY) 2019 supplemental appropriation for nursing facilities and are contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

*EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division, by regulation, must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance. The General Assembly included additional funds to nursing facilities' and HIV nursing facilities' reimbursements to account for an additional trend adjustment for State Fiscal Year (SFY) 2019 in the SFY 2019 supplemental appropriation. The MO HealthNet Division is carrying out the General Assembly's intent by providing for a per diem increase to nursing facility and HIV nursing facility reimbursement rates by implementing an additional trend adjustment of one dollar and twenty-nine cents ($1.29) effective for dates of service February 1, 2019 through June 30, 2019. The per diem increase shall be reduced to fifty-four cents ($0.54) effective for dates of service beginning July 1, 2019. The additional trend adjustment is necessary to ensure that payments for nursing facility and HIV nursing facility per diem rates are in line with the funds appropriated for that purpose. An early effective date is required in order to utilize the appropriated funds in the current SFY 2019. There are a total of five hundred ten (510) nursing facilities and HIV nursing facilities currently enrolled in MO HealthNet that will receive a per diem increase to its reimbursement rate effective for dates of service beginning February 1, 2019. This emergency amendment will ensure payment for nursing facility and HIV nursing facility services to approximately twenty-four thousand (24,000) MO HealthNet participants in accordance with the appropriation authority. For the SFY 2019 payment to be made, a Medicaid State Plan Amendment was required to be submitted and approved by the Centers for Medicare and Medicaid Services (CMS). The State Plan Amendment was approved by CMS on March 21, 2019. This emergency amendment is necessary to protect the public health and welfare of MO HealthNet participants in nursing facilities and HIV nursing facilities. This emergency amendment is necessary to protect a governmental interest to reimburse nursing facilities and HIV nursing facilities as required by the General Assembly, and to provide MO HealthNet participants with quality nursing facility services. As a result, the MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest, which requires emergency action. The MO HealthNet Division has a compelling governmental interest in providing continued cash flow for nursing facility and HIV nursing facility services. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment covering this same material is published in this issue of the **Missouri Register**. This emergency amendment was filed May 9, 2019, becomes effective June 1, 2019, and expires December 30, 2019.*

(3) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed in 13 CSR 70-10.015, a nursing facility's reimbursement rate may be adjusted as described in this section. Subject to the limitations prescribed in 13 CSR 70-10.080, an HIV nursing facility's reimbursement rate may be adjusted as described in this section.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem

rate adjustments. Global per diem rate adjustments shall be added to the specified cost component ceiling.

1. FY-96 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of four and six-tenths percent (4.6%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

2. FY-97 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of three and seven-tenths percent (3.7%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

3. Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents ($2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents ($1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of three and four-tenths percent (3.4%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of two and one-tenth percent (2.1%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of one and ninety-four hundredths percent (1.94%) of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

9. FY-2004 nursing facility operations adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003, through June 30, 2004, of four dollars and thirty-two cents ($4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents ($3.78); and

B. The operations adjustment shall be added to the facility's current rate as of June 30, 2003, and is effective for payment dates after August 1, 2003.

10. FY-2007 quality improvement adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006, of three dollars and seventeen cents ($3.17) to improve the quality of life for nursing facility residents; and

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006, and is effective for dates of service beginning July 1, 2006, and after.

11. FY-2007 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007, of three dollars and zero cents ($3.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007, and is effective for dates of service beginning February 1, 2007, for payment dates after March 1, 2007.

12. FY-2008 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007, and is effective for dates of service beginning July 1, 2007.

13. FY-2009 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2008, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2008, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2008, and is effective for dates of service beginning July 1, 2008.

14. FY-2010 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2009, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2009, of five dollars and fifty cents ($5.50) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2009, and is effective for dates of service beginning July 1, 2009.

15. FY-2012 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on October 1, 2011, shall be granted an increase to their per diem rate effective for dates of service beginning October 1, 2011, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of September 30, 2011, and is effective for dates of service beginning October 1, 2011; and

C. This increase is contingent upon the federal assessment rate limit increasing to six percent (6%) and is subject to approval by the Centers for Medicare and Medicaid Services.

16. FY-2013 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2012, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2012, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2012, and is effective for dates of service beginning July 1, 2012; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

17. FY-2014 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2013, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2013, of three percent (3.0%) of their current rate, less certain fixed cost items. The fixed cost items are the per diem amounts included in the facility's current rate from the following: subsection (2)(O) of 13 CSR 70-10.110, paragraphs (11)(D)1., (11)(D)2., (11)(D)3., (11)(D)4., (13)(B)3., and (13)(B)10. of 13 CSR 70-10.015;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2013, and is effective for dates of service beginning July 1, 2013; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

18. FY-2015 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2014, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2014, of one dollar and twenty-five cents ($1.25) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2014, and is effective for dates of service beginning July 1, 2014; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

19. January 1, 2016 – June 30, 2016 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on January 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning January 1, 2016, of two dollars and nine cents ($2.09) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment will not be added to the facility's rate after June 30, 2016; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services and sufficient funding available through the Tax Amnesty Fund.

20. Continuation of FY-2016 trend adjustment and FY-2017 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall continue to be granted an increase to their per diem rate effective for dates of service beginning July 1, 2016, of two dollars and nine cents ($2.09);

B. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2016, of two dollars and eighty-three cents ($2.83) to allow for a trend adjustment to ensure quality nursing facility services;

C. The trend adjustment of two dollars and eighty-three cents ($2.83) shall be added to the facility's rate as of June 30, 2016, which includes the two dollars and nine cents ($2.09) increase, and is effective for dates of service beginning July 1, 2016; and

D. These increases are contingent upon approval by the Centers for Medicare and Medicaid Services.

21. FY-2018 per diem adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on August 1, 2017, shall be subject to a decrease in their per diem rate effective for dates of services August 1, 2017 through June 30, 2018, of five dollars and thirty-seven cents ($5.37);

B. The per diem adjustment of five dollars and thirty-seven cents ($5.37) shall be deducted from the facility's current rate as of July 31, 2017, and is effective for dates of service beginning August 1, 2017;

C. Effective for dates of service beginning July 1, 2018, the per diem decrease shall be reduced to four dollars and eighty-three cents ($4.83). A per diem adjustment of fifty-four cents ($0.54) shall be added to the facilities current rate as of June 30, 2018, which includes the five dollars and thirty-seven cents ($5.37) decrease, and is effective for dates of service beginning July 1, 2018; and

D. This decrease is contingent upon approval by the Centers for Medicare and Medicaid Services.

22. FY-2019 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2018, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2018, of seven dollars and seventy-six cents ($7.76) to allow for a trend adjustment to ensure quality nursing facility services;

B. The rate to which the FY-2019 trend adjustment of seven dollars and seventy-six cents ($7.76) shall be added is the facilities' rate as of July 1, 2018 set forth in subparagraph (3)(A)21.C. and is effective for dates of service beginning July 1, 2018. This trend adjustment shall result in a rate no greater than eight dollars and thirty cents ($8.30) higher than the rate in effect on January 1, 2018; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

23. FY-2019 additional trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2019, shall be granted an increase to their per diem rate effective for dates of service February 1, 2019 through June 30, 2019, of one dollar and twenty-nine cents ($1.29) to allow for a trend adjustment to ensure quality nursing facility services;

B. The per diem adjustment of one dollar and twenty-nine cents ($1.29) shall be added to the facility's rate as of January 31, 2019, and is effective for dates of service beginning February 1, 2019 through June 30, 2019;

C. Effective for dates of service beginning July 1, 2019, the per diem increase shall be reduced to fifty-four cents ($0.54). A per diem adjustment of seventy-five cents ($0.75) shall be deducted from the facility's rate as of June 30, 2019, which includes the one dollar and twenty-nine cents ($1.29) increase, and is effective for dates of service beginning July 1, 2019.

D. These per diem adjustments are contingent upon approval by the Centers for Medicare and Medicaid Services.

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016. Original rule filed July 1, 2008, effective Jan. 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed May 9, 2019, effective June 1, 2019, expires Dec. 30, 2019. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance. The division is adding subsection (Q) to section (2) and amending subsections (2)(O) and (P).

PURPOSE: This amendment provides for a change in the Nursing Facility Reimbursement Allowance (NFRA) rate to twelve dollars and ninety-three cents ($12.93) effective July 1, 2018.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division, finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide nursing facility services to individuals eligible for the MO HealthNet nursing facility program. This emergency amendment changes the NFRA rate from thirteen dollars and forty cents ($13.40) to twelve dollars and ninety-three cents ($12.93) effective July 1, 2018. The NFRA needs to be established at an appropriate level in order to collect state revenues and to ensure funds are available to pay for MO HealthNet participants in participating MO HealthNet nursing facilities. The NFRA is being reduced to a level that is appropriate and sufficient to reimburse the services provided by MO HealthNet nursing facilities without collecting more funds than are needed to pay the nursing facilities. An early effective date is required in order to collect the appropriate level of funds in SFY 2019. The reduction in the NFRA will provide additional cash flow to the nursing facilities, allowing the nursing facilities to retain more funds on which to operate. The reduction in the NFRA assessment will provide additional cash flow to approximately five hundred twenty-nine (529) nursing facilities, including five hundred ten (510) nursing facilities that participate in the MO HealthNet program and provide nursing facility services to approximately twenty-four thousand (24,000) MO HealthNet participants. This emergency amendment is necessary to protect the public health and welfare of senior Missourians in nursing facilities. This emergency amendment is necessary to protect a governmental interest in collecting the appropriate level of NFRA assessments to reimburse nursing facilities and to provide MO HealthNet participants with quality nursing facility services. As a result, the MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest which requires emergency action. The MO HealthNet Division has a compelling governmental interest in providing continued cash flow for nursing facility services. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****. This emergency amendment was filed May 9, 2019, becomes effective June 1, 2019, and expires December 30, 2019.*

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in subsection (1)(B) above, are as follows:

(O) Effective July 1, 2012, the NFRA will be twelve dollars and eleven cents ($12.11) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K); *[and]*

(P) Effective July 1, 2015, the NFRA will be thirteen dollars and forty cents ($13.40) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K)*[.]***; and**

(Q) Effective July 1, 2018, the NFRA will be twelve dollars and ninety-three cents ($12.93) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K).

AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.424, 198.427, 198.431, 198.433, 198.436, [and] ***208.153,*** *208.159, [RSMo 2000, sections 208.153] and 208.201, RSMo [Supp. 2013]* ***2016, and*** *sections 198.421[, RSMo Supp. 2014,] and [section] 198.439, RSMo Supp. [2015]* ***2018****. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed May 9, 2019, effective June 1, 2019, expires Dec. 30, 2019. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

PROPOSED AMENDMENT

5 CSR 20-400.220 Application for Substitute Certificate of License to Teach. The State Board of Education is proposing to amend sections (1)-(5).

PURPOSE: This amendment is to update the requirements for a Substitute Certificate of License to Teach.

(1) An applicant for a substitute Missouri certificate of license to teach who has successfully completed sixty (60) semester hours or more of **college level** credit from a*[n]* **regionally-accredited** academic degree granting institution *[which is contained within the United States Department of Education's Directory of Post-Secondary Institutions, or approved by the commissioner of education, and possesses good moral character]* **recognized by the Department of Elementary and Secondary Education (department)** may be granted a substitute Missouri certificate of license to teach pursuant to the rules promulgated by the State Board of Education (board).

(2) An applicant for a career/technical substitute Missouri certificate of license to teach who has successfully completed **the following may be granted a substitute Missouri certificate of license to teach pursuant to the rules promulgated by the board**:

(A) A bachelor's degree in an area appropriate for the career/technical area sought and four thousand (4,000) hours of *[locally]* **department** approved, related occupational experience; or

(B) An associate's degree in an area appropriate for the career/technical area sought and five thousand (5,000) hours of *[locally]* **department** approved, related **occupational** experience; or

(C) Six thousand (6,000) hours of *[locally]* **department** approved, related occupational experience*[; or]***.**

[(D) Approved by the commissioner of education and possesses good moral character may be granted a career/technical substitute Missouri certificate of license to teach for a period of four (4) years.]

(3) *[An applicant for a substitute Missouri certificate of license to teach who holds a valid Missouri certificate of license to teach in a content or career/technical area; or approved by the commissioner of education and possesses good moral character may be granted a substitute Missouri certificate of license to teach for a period of four (4) years.]* Applicants may renew the substitute certificate of license to teach by completing *[a new fingerprint report every four (4) years or when employed by a new school district's required fingerprinting.]* **the following requirements:**

(A) A new fingerprint background check clearance every four (4) years or when employed by a new school district; and

(B) One (1) hour of professional development and/or district training annually.

[(4) Applications for a substitute Missouri certificate of license to teach shall be confirmed by the hiring school district in a manner designated by the Department of Elementary and Secondary Education (DESE).]

*[(5)]***(4)** An application is not considered officially filed with the *[State Board of Education ([]*board*[])]* until it has been determined by the board or *[DESE]* **department** staff to be completed and the application is submitted on the forms provided by the board, signed, and accompanied by two (2) full sets of fingerprints with the appropriate fee as set by the Missouri State Highway Patrol (Highway Patrol) and/or Federal Bureau of Investigation (FBI) and any other applicable forms and/or fees. All information should be received by the board within ninety (90) days of the date of the application.

(A) The applicant is responsible for submitting the fingerprints in the manner acceptable to the Highway Patrol and/or FBI and the payment of any fees required by the Highway Patrol and/or FBI.

*AUTHORITY: sections 161.092, [168.021] **168.011**, 168.071, and 168.081, RSMo [Supp.] 2016**,** and section [168.011] **168.021**, RSMo [2000] **Supp. 2018**. This rule previously filed as 5 CSR 80-800.290. Emergency rule filed July 30, 1999, effective Aug. 9, 1999, expired Jan. 26, 2000. Original rule filed July 30, 1999, effective Feb. 29, 2000. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 2, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500)

in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, ATTN: Dr. Paul Katnik, Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480 or by email to educatorquality@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

PROPOSED RULE

13 CSR 70-3.310 Chiropractic Services

PURPOSE: The purpose of this rule is to establish the Department of Social Services' MO HealthNet Division guidelines regarding coverage and reimbursement for chiropractic services as mandated in House Bill 1516, 99th General Assembly, section 208.152 RSMo.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Administration. The Chiropractic Program shall be administered by the MO HealthNet Division, Department of Social Services. The chiropractic services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the MO HealthNet Division and shall be included in the MO HealthNet *Physician Provider Manual*, which is incorporated by reference and made part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at, http://manuals.momed.com/manuals/, May 15, 2019. This rule does not incorporate any subsequent amendments or additions. Chiropractic services covered by the MO HealthNet program shall include only those which are clearly shown to be medically necessary. The MO HealthNet Division considers medically necessary when all of the following criteria are met: The member has a neuromusculoskeletal disorder; and the medical necessity for treatment is clearly documented; and improvement is documented within the initial two (2) weeks of chiropractic care. If no improvement is documented within the initial two (2) weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified. If no improvement is documented within thirty (30) days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary. The division reserves the right to effect changes in services, limitations, and fees with proper notification to MO HealthNet chiropractic providers.

(2) Provider Participation. To be eligible for participation in the MO HealthNet Chiropractic Program, a provider must be licensed to practice chiropractic by complying with the provisions of Chapter 331, RSMo and shall have signed a participation agreement to provide chiropractic services under the MO HealthNet program.

(3) Participant Eligibility. Any person who is eligible for Title XIX benefits from the Family Support Division and who is found to be in need of chiropractic services in accordance with the procedures described in this rule shall be deemed eligible to receive these services.

(4) Chiropractic Services. Up to twenty (20) visits per year are covered for services limited to examinations, diagnoses, adjustments, manipulations and treatments of malpositioned articulations, and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice.

(5) Records Retention. Providers who provide chiropractic services must follow section 13 CSR 70-3.030.

AUTHORITY: section[s] 208.152, ***RSMo Supp 2018,*** *and* ***section*** *660.017, RSMo 2016. Original rule filed May 15, 2019.*

PUBLIC COST: This proposed rule will cost state agencies or political divisions $5.8 million in the first year of the program, but will save money once the program is established.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Social Services
Division Title: MO HealthNet Division
Chapter Title: Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

Rule Number and Name:	13 CSR 70-3.310 Chiropractic Services
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
MO HealthNet Division	**$5.8 million (GR + FED)**

III. WORKSHEET

One Time Costs		
new provider type (FFS)	50/50 match	$200,000.00
actuarial cost (MC)	50/50 match	$50,000.00
TOTAL		$250,000.00

Total Cost						
	TOTAL		FF		GR	
FY20	$	10,896,482	$	7,104,833	$	3,791,649
FY21	$	11,210,478	$	7,309,568	$	3,900,910
FY22	$	11,636,476	$	7,587,331	$	4,049,145

Alternative treatments such as: chiropractic services, physical therapy, and acupuncture as well as cognitive-behavioral therapy in lieu of prescribing opioids for pain.			
	TOTAL	FF	GR
FY20	$5,300,000	$3,455,759	$1,844,241
FY21	$27,900,000	$18,191,637	$9,708,363
FY22	$29,400,000	$19,169,682	$10,230,318

Total Cost in lieu of opioids			
	TOTAL	FF	GR
FY20	$5,846,482	$3,774,074	$2,072,408
FY21	($16,689,523)	($10,882,069)	($5,807,454)
FY22	($17,763,524)	($11,582,351)	($6,181,173)

IV. ASSUMPTIONS

The first year of the chiropractic program will result in a fiscal impact, however in following years, adding chiropractic services may prevent opioid and other prescription pain reliever abuse and the costs associated with it, resulting in a savings to MO HealthNet.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 6—Emergency Ambulance Program

PROPOSED AMENDMENT

13 CSR 70-6.010—*[Emergency]* Ambulance *[Program]* *Treat No Transport*

PURPOSE: This amendment establishes the regulatory basis for the administration of the emergency ambulance program when services are provided on-site by a licensed emergency medical technician or by a paramedic and transportation is not required.

(1) Administration. The MO HealthNet ambulance program shall be administered by the Department of Social Services, MO HealthNet Division. The ambulance program services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the MO HealthNet Division and shall be included in the ambulance program provider manual, which is incorporated by reference [*in this rule*] and made part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, *[October 1, 2007]* **May 15, 2019**. This rule does not incorporate any subsequent amendments or additions.

(3) Participant Eligibility. The ambulance provider must ascertain the patient's MO HealthNet status before billing for services. The participant's MO HealthNet/*[MC+]***Managed Care** eligibility is determined by the Family Support Division. The participant must be eligible for MO HealthNet on the date that a service is provided in order for a provider to receive MO HealthNet reimbursement. It is the provider's responsibility to determine the coverage benefits for a participant based on their type of assistance as outlined in the ambulance program manual. The participant's eligibility shall be verified in accordance with methodology outlined in the ambulance program manual.

(5) Services Covered and Service Limitations. The MO HealthNet ambulance manual shall provide the detailed listing of procedure codes and pricing information covered by the MO HealthNet ambulance program.

(A) **Covered** *[A]***a**mbulance services are *[covered if they are emergency services and transportation is made to the nearest appropriate hospital]—*

1. Transportation is made to the nearest appropriate hospital when the criteria for emergency services is met (see (5)(B) below);

2. On-site treatment provided by an emergency medical technician or by a paramedic that meets the following criteria:

A. The treatment is a result of an emergent or immediate response made by a licensed ambulance service;

B. The emergency medical technician (EMT) or paramedic provides an assessment to determine the MO HealthNet participant's medical condition;

C. Medically necessary treatment is provided to the participant on-site; and

D. The participant is not transported by the responding service provider to an emergency department; and

3. On-site referral for further treatment that meets the following criteria:

A. The referral is a result of an emergent or immediate response made by a licensed ambulance services;

B. The EMT or paramedic provides an assessment to determine the MO HealthNet participants medical condition;

C. The referral is provided to the participant; and

D. The participant is not transported by the responding service provider to an emergency department.

(11) Records Retention. The enrolled MO HealthNet ambulance provider shall *[agree to]* keep any records necessary to *[disclose the extent of]* **fully document compliance with this regulation and the** services the provider furnishes to participants. These records must be retained for *[five (5)]* **seven (7)** years from the date of service. Fiscal and medical records **must** coincide with and fully document services billed to the MO HealthNet agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the MO HealthNet program, as specified above, is a violation of this regulation.

*AUTHORITY: sections [208.152,] 208.201[,] and **660.017,** RSMo [Supp. 2007] **2016, and section 208.152, RSMo Supp. 2018**. Original rule filed Feb. 10, 2006, effective Sept. 30, 2006. Amended: Filed Aug. 1, 2006, effective Feb. 28, 2007. Amended: Filed Aug. 23, 2007, effective March 30, 2008. Amended: Filed July 31, 2008, effective Feb. 28, 2009. Amended: Filed May 15, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dolloars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dolloars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates. The division is adding paragraph (3)(A)23.

PURPOSE: This proposed amendment provides for a per diem increase to nursing facility and HIV nursing facility per diem reimbursement rates of one dollar and twenty-nine cents ($1.29) effective for dates of service February 1, 2019 through June 30, 2019. The per diem increase shall be reduced to fifty-four cents ($0.54) effective for dates of service beginning July 1, 2019. These per diem adjustments correspond to the state fiscal year (SFY) 2019 supplemental appropriation for nursing facilities and are contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

(3) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed in 13 CSR 70-10.015, a nursing facility's reimbursement rate may be adjusted as described in this section. Subject to the limitations prescribed in 13 CSR 70-10.080, an HIV nursing facility's reimbursement rate may be adjusted as described in this section.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments. Global per diem rate adjustments shall be added to the specified cost component ceiling.

1. FY-96 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of four and six-tenths percent (4.6%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

2. FY-97 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of three and seven-tenths percent (3.7%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

3. Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents ($2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents ($1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of three and four-tenths percent (3.4%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of two and one-tenth percent (2.1%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of one and ninety-four hundredths percent (1.94%) of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

9. FY-2004 nursing facility operations adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003, through June 30, 2004, of four dollars and thirty-two cents ($4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents ($3.78); and

B. The operations adjustment shall be added to the facility's current rate as of June 30, 2003, and is effective for payment dates after August 1, 2003.

10. FY-2007 quality improvement adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006, of three dollars and seventeen cents ($3.17) to improve the quality of life for nursing facility residents; and

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006, and is effective for dates of service beginning July 1, 2006, and after.

11. FY-2007 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007, of three dollars and zero cents ($3.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007, and is effective for dates of service beginning February 1, 2007, for payment dates after March 1, 2007.

12. FY-2008 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007, and is effective for dates of service beginning July 1, 2007.

13. FY-2009 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2008, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2008, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2008, and is effective for dates of service beginning July 1, 2008.

14. FY-2010 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2009, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2009, of five dollars and fifty cents ($5.50) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2009, and is effective for dates of service beginning July 1, 2009.

15. FY-2012 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on October 1, 2011, shall be granted an increase to their per diem rate effective for dates of service beginning October 1, 2011, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of September 30, 2011, and is effective for dates of service beginning October 1, 2011; and

C. This increase is contingent upon the federal assessment rate limit increasing to six percent (6%) and is subject to approval by the Centers for Medicare and Medicaid Services.

16. FY-2013 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2012, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2012, of six dollars and zero cents ($6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2012, and is effective for dates of service beginning July 1, 2012; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

17. FY-2014 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2013, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2013, of three percent (3.0%) of their current rate, less certain fixed cost items. The fixed cost items are the per diem amounts included in the facility's current rate from the following: subsection (2)(O) of 13 CSR 70-10.110, paragraphs (11)(D)1., (11)(D)2., (11)(D)3., (11)(D)4., (13)(B)3., and (13)(B)10. of 13 CSR 70-10.015;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2013, and is effective for dates of service beginning July 1, 2013; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

18. FY-2015 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2014, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2014, of one dollar and twenty-five cents ($1.25) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2014, and is effective for dates of service beginning July 1, 2014; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

19. January 1, 2016 – June 30, 2016 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on January 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning January 1, 2016, of two dollars and nine cents ($2.09) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment will not be added to the facility's rate after June 30, 2016; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services and sufficient funding available through the Tax Amnesty Fund.

20. Continuation of FY-2016 trend adjustment and FY-2017 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall continue to be granted an increase to their per diem rate effective for dates of service beginning July 1, 2016, of two dollars and nine cents ($2.09);

B. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2016, of two dollars and eighty-three cents ($2.83) to allow for a trend adjustment to ensure quality nursing facility services;

C. The trend adjustment of two dollars and eighty-three cents ($2.83) shall be added to the facility's rate as of June 30, 2016, which includes the two dollars and nine cents ($2.09) increase, and is effective for dates of service beginning July 1, 2016; and

D. These increases are contingent upon approval by the Centers for Medicare and Medicaid Services.

21. FY-2018 per diem adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on August 1, 2017, shall be subject to a decrease in their per diem rate effective for dates of services August 1, 2017 through June 30, 2018, of five dollars and thirty-seven cents ($5.37);

B. The per diem adjustment of five dollars and thirty-seven cents ($5.37) shall be deducted from the facility's current rate as of July 31, 2017, and is effective for dates of service beginning August 1, 2017;

C. Effective for dates of service beginning July 1, 2018, the per diem decrease shall be reduced to four dollars and eighty-three cents ($4.83). A per diem adjustment of fifty-four cents ($0.54) shall be added to the facilities current rate as of June 30, 2018, which includes the five dollars and thirty-seven cents ($5.37) decrease, and is effective for dates of service beginning July 1, 2018; and

D. This decrease is contingent upon approval by the Centers for Medicare and Medicaid Services.

22. FY-2019 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2018, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2018, of seven dollars and seventy-six cents ($7.76) to allow for a trend adjustment to ensure quality nursing facility services;

B. The rate to which the FY-2019 trend adjustment of seven dollars and seventy-six cents ($7.76) shall be added is the facilities' rate as of July 1, 2018 set forth in subparagraph (3)(A)21.C. and is effective for dates of service beginning July 1, 2018. This trend adjustment shall result in a rate no greater than eight dollars and thirty cents ($8.30) higher than the rate in effect on January 1, 2018; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

23. FY-2019 additional trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2019, shall be granted an increase to their per diem rate effective for dates of service February 1, 2019 through June 30, 2019, of one dollar and twenty-nine cents ($1.29) to allow for a trend adjustment to ensure quality nursing facility services;

B. The per diem adjustment of one dollar and twenty-nine cents ($1.29) shall be added to the facility's rate as of January 31, 2019, and is effective for dates of service beginning February 1, 2019 through June 30, 2019;

C. Effective for dates of service beginning July 1, 2019, the per diem increase shall be reduced to fifty-four cents ($0.54). A per diem adjustment of seventy-five cents ($0.75) shall be deducted from the facility's rate as of June 30, 2019, which includes the one dollar and twenty-nine cents ($1.29) increase, and is effective for dates of service beginning July 1, 2019.

D. These per diem adjustments are contingent upon approval by the Centers for Medicare and Medicaid Services.

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016. Original rule filed July 1, 2008, effective Jan. 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed May 9, 2019, effective June 1, 2019, expires Dec. 30, 2019. Amended: Filed May 9, 2019.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately $5,038,694 in SFY 2019.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 10 - Nursing Home Program

Rule Number and Name:	13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services MO HealthNet Division	Estimated Cost for SFY 2019 = $5,038,694
Non-State Government Owned Nursing Facilities (46)	No estimated costs of compliance for SFY 2019.

III. WORKSHEET

Description	Nursing Facility Rate Increase	Hospice Nursing Home Room & Board	Total Impact
Estimated Paid Days – February 1, 2019 – June 30, 2019	3,640,930	277,963	
Per Diem Increase – Effective February 1, 2019 – June 30, 2019	$1.29	$1.23	
Estimated Impact – SFY 2019	$4,696,799	$341,895	$5,038,694
State Share (34.797%)	$1,634,345	$118,969	$1,753,314
Federal Share (65.203%)	$3,062,454	$222,923	$3,285,380

IV. ASSUMPTIONS

Department of Social Services, MO HealthNet Division: The above impact to DSS, MHD was calculated using the following assumptions:

Estimated Paid Days:

Nursing Facility:
The estimated paid days for February 2019 – June 2019 for nursing facilities are based on the average Medicaid days paid for nursing facility services from August 2018 – January 2019.

Hospice:

The estimated paid days for February 2019 – June 2019 for hospice are based on the actual hospice days provided in nursing facilities from January 2018 through December 2018 and prorated for February 2019 – June 2019.

Non-State Government Owned Nursing Facilities (46): This proposed amendment provides for a per diem increase to nursing facility and HIV nursing facility per diem reimbursement rates of one dollar and twenty-nine cents ($1.29) effective for dates of service February 1, 2019 through June 30, 2019, so there are no costs of compliance to Medicaid enrolled non-state government owned nursing facilities.

Hospice: Hospice providers may be impacted by this regulation because reimbursement for hospice services provided in nursing facilities are based on the nursing facility per diem rate. MHD conducted a fiscal analysis using 13 CSR 70-50.010 to estimate the impact to hospice. Please note this is an estimated analysis with the assumption of hospice appropriation authority.

Hospice Nursing Home Room and Board services are reimbursed 95% of the nursing facility per diem rate. The per diem increase of $1.29 to the nursing facility rate effective for dates of service beginning February 1, 2019 through June 30, 2019 computes to an increase to hospice reimbursement rates resulting from this amendment of $1.23 ($1.29 x 95%).

Impact on Home and Community Based Services (HCBS):

HCBS provided on a monthly basis are limited to a percentage of the average monthly nursing facility payment (referred to as the HCBS cost cap). The HCBS cost cap for a given SFY is based on the average monthly nursing facility payments for the 12 months ending in April of the previous SFY. Therefore, the per diem increase of $1.29 to the nursing facility rate effective for dates of service February 1, 2019 through June 30, 2019 will not impact the HCBS cost cap for SFY 2019 but may impact the HCBS cost cap for SFY 2020. The HCBS cost cap is estimated to increase in SFY 2020 by 0.29% as a result of this amendment. This may increase the amount of services, and the payments, for MO HealthNet participants that are at the cap.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance. The division is adding subsection (Q) to section (2) and amending subsections (2)(O) and (P).

PURPOSE: This amendment provides for a change in the Nursing Facility Reimbursement Allowance (NFRA) rate to twelve dollars and ninety-three cents ($12.93) effective July 1, 2018.

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in subsection (1)(B) above, are as follows:

(O) Effective July 1, 2012, the NFRA will be twelve dollars and eleven cents ($12.11) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K); *[and]*

(P) Effective July 1, 2015, the NFRA will be thirteen dollars and forty cents ($13.40) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K)*[.]***; and**

(Q) Effective July 1, 2018, the NFRA will be twelve dollars and ninety-three cents ($12.93) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K).

AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.424, 198.427, 198.431, 198.433, 198.436, [and] ***208.153,*** *208.159, [RSMo 2000, sections 208.153]* and *208.201, RSMo [Supp. 2013]* ***2016, and*** *sections 198.421[, RSMo Supp. 2014,]* and *[section]* 198.439, RSMo Supp. *[2015]* ***2018****. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed May 9, 2019, effective June 1, 2019, expires Dec. 30, 2019. Amended: Filed May 9, 2019.*

PUBLIC COST: In SFY 2019, for public state agencies this proposed amendment will result in a reduction of NFRA assessment revenue of approximately $6.8 million and a reduction in expenditures of $4.4 million for a net impact of $2.4 million. For non-state government nursing facilities this proposed amendment will result in a reduction of NFRA assessments of approximately $0.5 million and a reduction of nursing facility reimbursements of approximately $0.3 million for a net impact of $0.2 million.

PRIVATE COST: In SFY 2019, for private nursing facilities this proposed amendment will result in a reduction in nursing facility reimbursements of $3.8 million and a reduction in NFRA assessments of $6.3 million for a net impact of $2.5 million. For private hospice providers this proposed amendment will result in a reduction of hospice nursing home room and board reimbursements of $0.3 million.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Social Services
Division Title: MO HealthNet Division
Chapter Title: Nursing Home Program

Rule Number and Name:	13 CSR 70-10.110 Nursing Facility Reimbursement Allowance (NFRA)
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services MO HealthNet Division	
- NFRA Assessment	Estimated decrease in NFRA Assessment Revenues for SFY 2019: $6,864,350
- Nursing Facility Services	Estimated decrease in Nursing Facility Expenditures for SFY 2019: $4,092,801
- Hospice Nursing Home Room & Board Services	Estimated decrease in Hospice Expenditures for SFY 2019: $302,699
Non-State Government Owned Nursing Facilities (46)	
- NFRA Assessment	Estimated decrease in NFRA Assessment for SFY 2019: $517,276
- Nursing Facility Services	Estimated decrease in Nursing Facility Reimbursement for SFY 2019: $281,647

III. WORKSHEET

Description	Gov't NFs	Non-Gov't NFs	Total NFs
Estimated Annual Assessment Days: SFY 2019	1,100,588	13,504,411	14,604,999
Proposed NFRA Rate	$12.93	$12.93	$12.93
Current NFRA Rate	$13.40	$13.40	$13.40
Decrease in NFRA Rate	($0.47)	($0.47)	($0.47)
Estimated Decrease in NFRA Assessment for SFY 2019 (Estimated Days times Decrease in the NFRA)	($517,276)	($6,347,073)	($6,864,350)
Less: Decrease in Nursing Facility Reimbursement due to NFRA being an Allowable Cost (per 13 CSR 70-10.015)	($281,647)	($3,811,154)	($4,092,801)
Net Impact	($235,630)	($2,535,919)	($2,771,549)

IV. ASSUMPTIONS

This proposed amendment provides for a change to the Nursing Facility Reimbursement Allowance (NFRA) assessment rate per patient day. Effective July 1, 2018, the NFRA rate decreases from $13.40 per patient day to $12.93 per patient day, resulting in a decrease to the NFRA assessment owed by nursing facilities. This results in a savings to the nursing facilities and a reduction in assessment revenue to the state.

The estimated annual assessment days for SFY 2019 is based on the annualized days from each facility's December 2017 CON Survey, as set forth in regulation. These days were multiplied by the difference between the proposed NFRA rate of $12.93 and the current NFRA rate of $13.40 to determine the impact of the NFRA rate change.

Impact on Nursing Facility Reimbursement:

The NFRA rate change will also change the per diem reimbursement rates for nursing facilities since the NFRA is an allowable cost for reimbursement under 13 CSR 70-10.015. To account for the NFRA being an allowable cost, the current NFRA rate is included as part of the nursing facility's total per diem reimbursement rate. Since the NFRA rate is decreasing by $0.47, the nursing facility per diem rate will also decrease by $0.47, resulting in decreased reimbursement to the nursing facilities and decreased expenditures to the state.

Impact on Hospice Reimbursement:

Hospice providers will be impacted by this regulation because reimbursement for hospice nursing home room and board is based on the reimbursement to nursing facilities. Therefore, MHD conducted a fiscal analysis using 13 CSR 70-50.010 to estimate the impact to hospice. Please note this is an estimated analysis with the assumption of hospice appropriation authority.

Hospice Nursing Home Room and Board services are reimbursed 95% of the nursing facility per diem rate. The per diem decrease of $0.47 to the nursing facility per diem rate effective

for dates of service beginning July 1, 2018 computes to a decrease to hospice reimbursement rates resulting from this amendment of $0.45 ($0.47 x 95%).

MHD used the following methodology to determine the decrease in reimbursement to nursing facilities and hospice nursing home room and board services:

Description	Gov't NFs	Non-Gov't NFs	Total NFs	Hospice NH Room & Board	Total Impact
Estimated Paid Days – SFY 2019	599,248	8,108,839	8,708,087	672,664	
Per Diem Decrease – July 1, 2018	($0.47)	($0.47)	($0.47)	($0.45)	
Estimated Decrease in Nursing Facility Reimbursement – SFY 2019	($281,647)	($3,811,154)	($4,092,801)	($302,699)	($4,395,500)
State Share (34.797%)	($98,005)	($1,326,167)	($1,424,172)	($105,330)	($1,529,502)
Federal Share (65.203%)	($183,642)	($2,484,987)	($2,668,629)	($197,369)	($2,865,998)

Estimated Paid Days:

Nursing Facility:

The estimated paid days for SFY 2019 for nursing facilities are based on the average Medicaid days paid for nursing facility services from August 2018 – January 2019.

Hospice:

The estimated paid days for SFY 2019 for hospice are based on the actual hospice days provided in nursing facilities from January 2018 through December 2018.

Impact on Home and Community Based Services (HCBS):

HCBS provided on a monthly basis are limited to a percentage of the average monthly nursing facility payment (referred to as the HCBS cost cap). The HCBS cost cap for a given SFY is based on the average monthly nursing facility payments for the 12 months ending in April of the previous SFY. Therefore, the per diem decrease of $0.47 to the nursing facility rate effective for dates of service beginning July 1, 2018 will not impact the HCBS cost cap for SFY 2019 but may impact the HCBS cost cap for SFY 2020. This may decrease the amount of services, and the payments, for MO HealthNet participants that are at the cap. The HCBS cost cap is estimated to decrease in SFY 2020 by 0.36%. This will decrease the amount of services, and the payments, for MO HealthNet participants that are at the cap.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Social Services
Division Title: MO HealthNet Division
Chapter Title: Nursing Facility Program

Rule Number and Title:	13 CSR 70-10.110 Nursing Facility Reimbursement Allowance (NFRA)
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
483	Nursing Facilities	Estimated savings for SFY 2019: $2,535,919
116	Hospice Providers	Estimated cost for SFY 2019: $302,699

III. WORKSHEET

Description	Gov't NFs	Non-Gov't NFs	Total NFs
Estimated Annual Assessment Days: SFY 2019	1,100,588	13,504,411	14,604,999
Proposed NFRA Rate	$12.93	$12.93	$12.93
Current NFRA Rate	$13.40	$13.40	$13.40
Decrease in NFRA Rate	($0.47)	($0.47)	($0.47)
Estimated Decrease in NFRA Assessment for SFY 2019 (Estimated Days times Decrease in the NFRA)	($517,276)	($6,347,073)	($6,864,350)
Less: Decrease in Nursing Facility Reimbursement due to NFRA being an Allowable Cost (per 13 CSR 70-10.015)	($281,647)	($3,811,154)	($4,092,801)
Net Impact	($235,630)	($2,535,919)	($2,771,549)

IV. ASSUMPTIONS

This proposed amendment provides for a change to the Nursing Facility Reimbursement Allowance (NFRA) assessment rate per patient day. Effective July 1, 2018, the NFRA rate decreases from $13.40 per patient day to $12.93 per patient day, resulting in a decrease to the NFRA assessment owed by nursing facilities. This results in a savings to the nursing facilities and a reduction in assessment revenue to the state.

The estimated annual assessment days for SFY 2019 is based on the annualized days from each facility's December 2017 CON Survey, as set forth in regulation. These days were multiplied by the difference between the proposed NFRA rate of $12.93 and the current NFRA rate of $13.40 to determine the impact of the NFRA rate change.

Impact on Nursing Facility Reimbursement:

The NFRA rate change will also change the per diem reimbursement rates for nursing facilities since the NFRA is an allowable cost for reimbursement under 13 CSR 70-10.015. To account for the NFRA being an allowable cost, the current NFRA rate is included as part of the nursing facility's total per diem reimbursement rate. Since the NFRA rate is decreasing by $0.47, the nursing facility per diem rate will also decrease by $0.47, resulting in decreased reimbursement to the nursing facilities and decreased expenditures to the state.

Impact on Hospice Reimbursement:

Hospice providers will be impacted by this regulation because reimbursement for hospice nursing home room and board is based on the reimbursement to nursing facilities. Therefore, MHD conducted a fiscal analysis using 13 CSR 70-50.010 to estimate the impact to hospice. Please note this is an estimated analysis with the assumption of hospice appropriation authority.

Hospice Nursing Home Room and Board services are reimbursed 95% of the nursing facility per diem rate. The per diem decrease of $0.47 to the nursing facility per diem rate effective for dates of service beginning July 1, 2018 computes to a decrease to hospice reimbursement rates resulting from this amendment of $0.45 ($0.47 x 95%).

MHD used the following methodology to determine the decrease in reimbursement to nursing facilities and hospice nursing home room and board services:

Description	Gov't NFs	Non-Gov't NFs	Total NFs	Hospice NH Room & Board	Total Impact
Estimated Paid Days – SFY 2019	599,248	8,108,839	8,708,087	672,664	
Per Diem Decrease – July 1, 2018	($0.47)	($0.47)	($0.47)	($0.45)	
Estimated Decrease in Nursing Facility Reimbursement – SFY 2019	($281,647)	($3,811,154)	($4,092,801)	($302,699)	($4,395,500)
State Share (34.797%)	($98,005)	($1,326,167)	($1,424,172)	($105,330)	($1,529,502)
Federal Share (65.203%)	($183,642)	($2,484,987)	($2,668,629)	($197,369)	($2,865,998)

Estimated Paid Days:

Nursing Facility:

The estimated paid days for SFY 2019 for nursing facilities are based on the average Medicaid days paid for nursing facility services from August 2018 – January 2019.

Hospice:

The estimated paid days for SFY 2019 for hospice are based on the actual hospice days provided in nursing facilities from January 2018 through December 2018.

Impact on Home and Community Based Services (HCBS):

HCBS provided on a monthly basis are limited to a percentage of the average monthly nursing facility payment (referred to as the HCBS cost cap). The HCBS cost cap for a given SFY is based on the average monthly nursing facility payments for the 12 months ending in April of the previous SFY. Therefore, the per diem decrease of $0.47 to the nursing facility rate effective for dates of service beginning July 1, 2018 will not impact the HCBS cost cap for SFY 2019 but may impact the HCBS cost cap for SFY 2020. This may decrease the amount of services, and the payments, for MO HealthNet participants that are at the cap. The HCBS cost cap is estimated to decrease in SFY 2020 by 0.36%. This will decrease the amount of services, and the payments, for MO HealthNet participants that are at the cap.

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 1—General Organization

PROPOSED AMENDMENT

16 CSR 20-1.010 General Organization. The Retirement System is amending section (2) to update the rule to more accurately reflect the structure of the Retirement System organization as it currently functions.

PURPOSE: The proposed amendment updates the rule to reflect LAGERS' organizational structure, authority of the LAGERS Board of Trustees to contract with service providers and non-substantive clean-up language and updates.

(2) The general administration and the responsibility for the proper operation of the system is vested in a board of trustees consisting of seven (7) persons. Three (3) trustees are elected by the employees who participate in the system, three (3) trustees are elected by the members of the governing bodies of those political subdivisions which participate in the system**,** and one (1) trustee is appointed by the governor. The board of trustees employs an executive secretary, **who may also be referred to as the executive director,** not one **(1)** of their number, who shall be the executive officer of the board **and a chief investment officer, not one (1) of their number, who shall report directly to the board on all system investment activity**. The board also **may** employ*[s]* or contract*[s]* for the services of *[an]* actuar*[y]***ies**, legal advisor**s**, investment counselors, medical advisors**,** *[and a]* certified public accountant**s**, and such other service **providers as the board shall deem necessary**.

*AUTHORITY: section 70.605.21, RSMo [1994] **2016**. Original rule filed Dec. 29, 1975, effective Jan. 8, 1976. Amended: Filed Oct. 31, 1979, effective Feb. 11, 1980. Amended: Filed Feb. 16, 1999, effective July 30, 1999. Non-substantive change filed May 1, 2018, published June 30, 2018. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri—Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.040 Refunds. The Retirement System is amending sections (2), (3), (4), and (5) to update the guidelines regarding refunds of employee contributions and reflect current practices including the use of electronic means of refund requests.

PURPOSE: The proposed amendment updates the existing rule to permit electronic refund applications and certifications and increase the frequency of refund payment dates, as well as non-substantive language updates, and clean-up.

(2) The employee must submit a written request for the refund of *[his/her]* **the member's** accumulated contributions*[, the request to be made out]* on a form furnished by the board**, which may be an electronic form**.

(3) The member's employer must certify*[, in writing,]* that the employee has left the employ of the employer.

(4) *[Missouri Local Government Employees']* **The** Retirement System (LAGERS) will not refund a member's accumulated contributions until the employer has remitted the employer statement certifying that the member is no longer receiving remuneration or making contributions to the system. *[Refunds will not be made before the expiration of sixty (60) days from the date of a member's termination of employment.]* Refunds are issued on the first *[working]* **and fifteenth** day**s** of a month **(or the first business day thereafter if the 1st or 15th day is not a business day)**.

(5) The executive secretary shall report to the board at each meeting of the board, the refunds of employees' accumulated contributions made by *[him/her]* **LAGERS** since the last meeting of the board. *[The reports shall be attached to and made a part of the minutes of the board meeting.]*

*AUTHORITY: section 70.605.21, RSMo [1994] **2016**. Original rule filed Dec. 29, 1975,effective Jan. 8, 1976. Amended: Filed Oct.6, 1983, effective Jan. 11, 1984. Amended: Filed Feb. 16, 1999, effective July 30, 1999. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.045 Application for Retirement. The Retirement System is amending sections (1) and (2) to update the guidelines regarding applications for retirement and reflect current practices including the use of electronic applications.

PURPOSE: The proposed amendment updates the rule to permit electronic filing of retirement applications and clarify that the rule applies to early service retirement applications as well as make non-substantive language updates and clean-up provisions.

(1) Any vested member who has attained the minimum **service** retirement age, **the minimum early service retirement age pursuant to section 70.670, RSMo,** or, if an election has been made in accordance with section 70.646, RSMo *[1994]* to provide for alternate eligibility, have years of attained age and credited service in force which total eighty (80) or more, may file a written **or electronic** application for retirement with the system, including the date on which the member desires *[his/her]* retirement to be effective.

(2) For purposes of section 70.645, RSMo *[1994]*, and this rule, the following factors shall determine the date that an application for retirement shall be deemed to have been filed with Missouri Local Government Employees' Retirement System (LAGERS):

(C) If the application is sent to LAGERS electronically or through facsimile transmission, the date and time the *[fax transmission]* **application** is received by LAGERS; and

(D) If the application is personally given to a LAGERS *[board member or]* employee, the date of personal delivery.

*AUTHORITY: sections 70.605.21, and 70.645, RSMo [1994] **2016**. Original rule filed Feb.16, 1999, effective July 30, 1999. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.056 Lump-Sum Cash Payout of Retirement Allowance. The Retirement System is amending the purpose and section (1) to correct a statutory reference and increase the reserve amount of payment that will make a member eligible to apply the optional retirement election providing for a lump-sum cash payout in lieu of a monthly benefit.

PURPOSE: The proposed amendment increase the value of reserve amount for accounts eligible to apply for a lump-sum payout and correct a statutory reference within the rule language.

*PURPOSE: This rule establishes the circumstances under which a member or former member may receive a lump-sum cash payout in lieu of a monthly benefit, as provided for in section 70.660.[1]**2**(4), RSMo [2000] regarding optional retirement elections.*

(1) A member or former member who is entitled to a retirement allowance, as defined in section 70.655 or section 70.765, RSMo *[2000]*, may, in accordance with section 70.660.*[1]***2**(4), elect to receive a lump-sum cash payout at retirement that is the actuarial equivalent of the retirement allowance otherwise payable, provided that the value of the reserve at the time of payment is less than *[ten]* **twenty** thousand dollars ($*[1]***2**0,000).

*AUTHORITY: section 70.605.21, RSMo [2000] **2016**. Original rule filed Oct. 17, 2001, effective May 30, 2002. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.070 Collection of Delinquent Payments. The Retirement System is amending sections (1) and (2) to update the procedure for when a political subdivision is delinquent in remitting payments to the system.

PURPOSE: The proposed amendment updates the rule to permit electronic means of communication, clarify the timeline for the collection of delinquent payments, and eliminate inconsistencies with 70.735 RSMo, as well as non-substantive language updates and clean-up provisions.

(1) The system *[shall notify]* **will provide** each political subdivision *[when its]* **with a monthly** employer statement **of account, which will indicate the** *[and]* remittance *[is]* due the system **from the political subdivision**.

(2) If any political subdivision fails to make any payment due**, as indicated on the employer statement of account, by the twelfth day of the month (or the first business day thereafter if the twelfth day is not a business day)**, the system shall make the payment due a receivable or shortage on the employer's statement and notify the political subdivision in writing**, which may be sent to the employer electronically or via U.S. Mail.** *[The political subdivision shall remit the shortage to the system within forty-five (45) days]* **If the political subdivision fails to make any payment due the retirement system for a period of sixty days (60) after the payment becomes due, as set forth above, the retirement system may consider the political subdivision delinquent and seek relief as provided in RSMo section 70.735**.

*AUTHORITY: sections 70.605.21. and 70.735, RSMo [1986] **2016**. Original rule filed Oct. 6, 1983, effective Jan. 11, 1984. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 20—Missouri Local Government Employees' Retirement System (LAGERS)
Chapter 2—Administrative Rules

PROPOSED AMENDMENT

16 CSR 20-2.105 *[Determination of Amount Otherwise Payable]* ***Redetermination of Allowances*** **During Deflation** ***and Consumer Pricing Indices To Be Considered***. The Retirement System is amending the title, purpose, and section (1), and adding a new section (2) to clarify how the Consumer Price Index will be used to redetermine allowances during deflation and which Consumer Price Indices may be considered by the Board of Trustees in making such redeterminations.

PURPOSE: The proposed amendment clarifies how retiree allowances are redetermined in periods of inflation subsequent to periods of deflation and expands the Consumer Price Indices the LAGERS Board of Trustees may consider in redetermining retiree allowances.

PURPOSE: The purpose of this rule is to [provide Missouri Local Government Employees' Retirement System's (LAGERS') interpretation of] ***clarify how retiree allowances will be redetermined pursuant to*** *section 70.655.7–.10 et. seq., RSMo, [regarding]* ***during periods of*** *deflation* ***and which Consumer Pricing Indices may be considered in making the redetermination****.*

(1) For purposes of calculating the redetermined amount of the allowance as set forth under section 70.655.7–.10 et. seq., RSMo, *[the Missouri Local Government Employees' Retirement System's (LAGERS') Board of Trustees interprets sections 70.655.7–.10 et.seq., RSMo, to not require an actual reduction in the redetermined amount of the retirant's allowance]* during periods of deflation*[. /]*, **i**f the annual Consumer Price Index (CPI) is negative, there shall be no actual reduction in the redetermined amount of the retiree*['/]*s' allowances. **However, in the next year in which the annual Consumer Price Index (CPI) is positive, the Board of Trustees may consider the cumulative net increase or decrease in the Consumer Price Index (CPI) inclusive of the negative and positive years when redetermining any amount of the retirees' allowances.**

(2) In order to continue the original intent of the use of the Consumer Price Index, as defined by section 70.655.7, RSMo, the Board of Trustees of the Retirement System may also consider the Consumer Price Index for All Urban Consumers (CPI-U), as determined by the United States Department of Labor, when redetermining any amount of the retirees' allowances.

AUTHORITY: section 70.605.21, RSMo [Supp. 2009] ***2016****. Original rule filed Nov. 12, 2009, effective May 30, 2010. Amended: Filed May 3, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Any interested person or entity may submit written comments in support of or in opposition to the proposed amendment. Comments should be directed to the Missouri Local Government Employees Retirement System (LAGERS), Attn: Jason A. Paulsmeyer, Chief Counsel, PO Box 1665, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register.*** *No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement Practices

PROPOSED AMENDMENT

20 CSR 100-1.030 Failure to Acknowledge Pertinent Communication. The director is amending sections (1), (2), and (3) and adding section (2), subsection (1)(A), and paragraphs (1)(A)1., (1)(A)2., and (1)(A)3.

PURPOSE: This amendment restructures the rule to provide greater clarity in interpreting the provisions of section 375.1007(2), RSMo regarding the handling and processing of claims.

(1) *[Every]* **The following conduct by an** insurer*[,]* **is deemed to be the type of conduct set forth in section 375.1007(2).** *[upon receiving notification of claim from any first-party claimant within ten (10) working days, shall]*

(A) Failing to acknowledge the receipt of *[the]* **a** notification **of claim from a first party claimant. For the purposes of this subsection, acknowledgment of receipt by an insurer may be made by either:**

1. Making *[unless]* payment *[is made]* within *[the period of time.]* **ten (10) working days of receipt;**

2. Sending the first party claimant a written acknowledgment within ten (10) working days of receipt and maintaining a copy of the written acknowledgment in the claim file of the insurer; or

3. Providing the first party claimant with an oral acknowledgment within ten (10) working days of receipt and *[If an acknowledgment is made by means other than writing,]* **making** an appropriate notation of **the date of** this acknowledgment *[shall be made]* in the claim file of the insurer *[and dated]. [Notification given to an agent of an insurer shall be notification to the insurer.]*

*[(2)]***(B) Failing to provide** *[A]***n** appropriate reply *[shall be made]* within ten (10) working days on all communications from any claimant *[which]* **that** reasonably suggests *[that]* a response is expected.

(2) For the purposes of subsection (1)(A), notification to any agent of the insurer, including a producer representing the insurer, constitutes notification to the insurer.

(3) *[Every insurer, upon receiving notification of claim, promptly shall provide]* **Provision of** necessary claim forms, instructions and reasonable assistance *[so that]* **to** first-party claimants *[can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this section]* within ten (10) working days of notification of a claim *[shall]* constitute**s** compliance with **sub**section (1)**(A)** of this rule.

AUTHORITY: sections 374.045 and 375.1000-375.1018, RSMo 2016. This rule was previously filed as 4 CSR 190-10.060(4). Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Aug. 16, 1978, effective Dec. 11, 1978. Amended: Filed Sept. 11, 1980, effective Feb. 16, 1981. Amended: Filed Sept. 14, 1981, effective Jan. 15, 1982. Amended: Filed Aug. 4, 1986, effective Jan. 1, 1987. Amended: Filed Jan. 5, 1987, effective June 1, 1987. Amended: Filed Aug. 4, 1987, effective Dec. 24, 1987. Amended: Filed Dec. 9, 1988, effective April 28, 1989. Amended: Filed Nov. 2, 1989, effective Feb. 15, 1990. Emergency amendment filed Feb. 21, 1990, effective March 5, 1990, expired June 2, 1990. Amended: Filed Feb. 26, 1990, effective June 11, 1990. Amended: Filed Dec. 12, 1990, effective June 10, 1991. Amended: Filed Oct. 1, 1996, effective June 30, 1997. Amended: Filed May 13, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 4—General

PROPOSED AMENDMENT

20 CSR 100-4.100 *[Required]* **Response to Inquiries by the Consumer Affairs Division**. The director is amending the purpose statement, section (1) and (2), and adding subsections (2)(A) through (2)(E).

PURPOSE: This amendment incorporates the definitions from rule 20 CSR 100-4.010 and clarifies the terms of the rule.

PURPOSE: This rule sets forth with greater specificity the [statutory requirements] ***standards*** *for responding to inquiries from the Division of Consumer Affairs, [required of all persons in this state,] pursuant to sections 354.190, 354.465, 354.717, 374.085, 374.110, 374.190, 375.938, 375.1009, 376.1375 and 384.015, RSMo.*

(1) As used in this rule, *["division" means the Consumer Affairs Division.]* **the following terms mean:**

(A) "Adequate response," a written response answering each inquiry with reasonable specificity. A person's acknowledgment of the division's inquiry is not an adequate response;

(B)"Department," the Department of Insurance, Financial Institutions and Professional Registration;

(C) "Division," the Division of Consumer Affairs;

(D) "Inquiry," each and every question or request for information submitted in writing to a person by the division concerning subjects which are within the division's authority to regulate or investigate; and

(E) "Person," any person as that term is defined in sections 374.046.17, 375.932(4), and 375.1002(3), RSMo, including "insurers" as that term is defined in sections 375.932(3) and 375.1002(2), RSMo, and any other entity, association, or individual, whether or not the director has granted a license or certificate of authority to the entity, association, or individual.

(2) Except as *[required]* **provided for** under subsection (2)(B)—

(A) Upon receipt of any inquiry from the division, every person shall mail to the division an adequate response to the inquiry within twenty (20) days from the date the division mails the inquiry. An envelope's postmark *[shall]* determines the date of mailing. When the requested response is not produced by the person within twenty (20) days, this nonproduction *[shall be]* **is** deemed a violation of this rule, unless the person can demonstrate that there is reasonable justification for that delay*[.]***;** and

(B) This rule *[shall]* **does** not apply to any other statute or regulation which requires a different time period for a person to respond to an inquiry by the department. If another statute or regulation requires a shorter response time, the shorter response time *[shall be met]* **is controlling**. This regulation operates only in the absence of any other applicable laws.

AUTHORITY: section 374.045, RSMo 2016. Original rule filed Oct. 1, 1996, effective June 30, 1997. Amended: Filed Nov. 3, 1997, effective June 30, 1998. Amended: Filed Nov. 1, 2007, effective July 30, 2008. Amended Filed: May 13, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 8—Market Conduct Examination

PROPOSED AMENDMENT

20 CSR 100-8.016 Examination Procedures. The director is amending the purpose statement, sections (3), (4), (5), and (6), deleting sections (1) and (2), creating a new section (3), and renumbering as necessary.

PURPOSE: This amendment removes language that is duplicative of

language in other regulations and adds a new provision giving insurance companies the opportunity to address issues relating to examination costs or data requests.

PURPOSE: This rule implements the purposes of section 374.185, RSMo, and establishes uniform standards for the director in applying the discretion authorized in issuing ***examination*** *warrants for market conduct examinations pursuant to sections 374.202 to 374.207, RSMo*

[(1) Prior to commencement of an on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan and proposed budget and provide the work plan and proposed budget to the company under examination.

(2) Market conduct examinations shall, to the extent feasible, utilize desk examinations and data requests prior to commencing on-site examination activity.]

*[(3)]***(1)** Market conduct examinations *[shall]* **will** be conducted in accordance with the provisions set forth in the National Association of Insurance Commissioners (NAIC) Market Regulation Handbook, or in department regulations, if inconsistent with the NAIC Market Regulation Handbook, for the type of examination being conducted.

*[(4)]***(2)** The examiner-in-charge *[shall]* **will** conduct a pre-examination conference with the company examination coordinator and key personnel to clarify expectations **approximately** thirty (30) days prior to commencement of the examination.

(3) If the insurer or company believes there is a significant increase from the original work plan's estimates of cost or a significant increase in the amount of data requested, the insurer or company may submit a request, in writing, for a review of the examination costs or data requests. Such request shall be submitted to the market regulation division director or chief examiner. The market regulation division director or chief examiner will provide a written response to the request within twenty (20) business days. Any request or response under this section shall be considered examination workpapers, subject to the confidentiality provisions of section 374.205, RSMo.

*[(5)]***(4)** If a**n** *[targeted]* examination is expanded beyond the scope of the **examination** warrant *[and the reasons provided to the company in the notice of examination required under this section,]*the director *[shall]* **will** modify the **examination** warrant or issue a new **examination** warrant and provide written notice to the company explaining the extent of the expansion and the reasons for the expansion. The division *[shall]* **will** provide a revised work plan to the company before the beginning of any significantly expanded examination, unless extraordinary circumstances *[indicating]* **indicate immediate action is necessary to avoid** a risk to consumers *[require immediate action]*.

*[(6)]***(5)** Prior to the conclusion of a market conduct examination, the examiner-in-charge *[shall]* **will** schedule and conduct an exit conference with the company as outlined by the NAIC Market Regulation Handbook.

AUTHORITY: sections 374.045, 374.185, and 374.205, ***374.207****, RSMo 2016. Original rule filed April 1, 2008, effective Nov. 30, 2008. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 8—Market Conduct Examination

PROPOSED AMENDMENT

20 CSR 100-8.040 Insurer Record Retention. The director is amending the purpose statement, authority section, sections (2), (3), (5), and (7), subsections (1)(G), (3)(A), (3)(D), (3)(E), (4)(A), (4)(C), (6)(A), and (6)(B), and paragraphs (3)(A)4., (3)(B)3., and (3)(B)4., deleting subsection (4)(B), and creating a new subsection (4)(B).

PURPOSE: This amendment clarifies standards for maintaining insurance records in compliance with Missouri law.

PURPOSE: This rule describes the requirements for record keeping for insurers and related entities doing business in this state. This regulation was adopted pursuant to the provisions of section 374.045, RSMo and to implement sections 287.350, 354.190, 354.465, 374.190, 374.210, 375.158, ***374.205,*** *379.343, and 379.475, RSMo and 144.027, 354.149, 354.717, 375.022, 375.150, 375.151, 375.926, 375.932, 375.938, 375.1002, and 375.1009, RSMo.*

(1) As used in this rule, the terms and phrases mean as follows:

(G) "Policy," as that term is defined in section 375.932(5), RSMo. The term "policy" *[shall]* also include**s** any evidence of coverage issued by a health maintenance organization to an enrollee.

(2) Records *[Required]* **Maintainance**. Every insurer transacting business in this state shall maintain its books, records, documents**,** and other business records in a manner so that the following practices of the insurer may be readily ascertained during market conduct examinations: claims handling and payment, complaint handling, termination, rating, underwriting and marketing. **Nothing in this regulation requires an insurer to create records that never existed; however, the division may request the creation of such records if it believes doing so will reduce examination costs.**

(3) Records to be Maintained. *[The following records shall be maintained:]* **An insurer that maintains its records in accordance with the following standards will be considered in compliance with Missouri law.**

(A) A Missouri policy record file *[shall be maintained]* for each Missouri policy issued*[, and]* shall be maintained for the duration of the current policy term plus two (2) calendar years. Missouri policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. Missouri policy records need not be segregated from the policy records of other states so long as they are readily available to Missouri market conduct examiners as *[required]* **set forth** under this rule. Missouri policy records shall include the

following:

1. The actual, completed application for each contract.

A. The application shall bear the signature of the applicant whenever the insurer intends to retain any right to contest any warranty, representation or condition contained in the application.

B. The application shall bear a clearly legible means by which an examiner can identify any insurance producer involved in the transaction. The examiners shall be provided with any information needed to determine the identity of said insurance producer;

2. Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, and any written or electronic correspondence to or from the insured pertaining to the coverage. If any of these records has already been filed with the department, a separate copy of the record need not be maintained in the individual policy files to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to that policy can be retrieved or recreated;

3. Any binder with terms and conditions that differ from the terms and conditions of the policy subsequently issued; and

4. Any guidelines, manuals or other information necessary for the reconstruction of the rating and underwriting of the policy. The maintenance at the site of a market conduct examination of a single copy of each of the above *[shall satisfy this requirement]* **will be considered satisfactory**. If any such rating or underwriting record is computer based, the records used to input the information into the computer system shall also be available to the examiners;

(B) A Missouri claim file shall be maintained for the calendar year in which the claim is closed plus three (3) years. The claim file shall be maintained so as to show clearly the inception, handling, and disposition of each claim. The claim file(s) shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A Missouri claim file(s) shall include the following:

1. Any notification of claim, proof of loss, claim form(s), proof of claim payment check/draft, notes, contract, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers, any written communication, and any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment and/or denial of the claim, and any claim manual(s) or other information necessary for reviewing the claim. Where a particular document pertains to more than one (1) file, insurers may satisfy the requirements of this paragraph by making available, at the site of a market conduct examination, a single copy of each document;

2. Documents in a claim file received from an insured, the insured's insurance producer, a claimant, the department or any other insurer shall bear the initial date of receipt date-stamped by the insurer in a legible form in ink or some other permanent manner. Unless the company provides the examiners with written procedures to the contrary, the earliest date stamped on a document will be considered the initial date of receipt;

3. In cases of a total loss on property claims for a motor vehicle, trailer, boat or outboard motor, **where the insurer utilizes the credit procedure contained in section 144.027, RSMo, for reimbursement of sales tax,** the claim file shall contain a copy of the certification described in section 144.027, RSMo**,** attesting to the amount of the insurance proceeds and any deductible obligation paid by the claimant regarding the loss*[. The certification shall contain a statement informing the claimant that the sales tax credit is valid for only one hundred eighty (180) days]*; and

4. If an insurer, as its regular business practice, places the responsibility for handling certain types of claims upon company personnel other than its claims personnel, the insurer need not duplicate its files for maintenance by claims personnel. These claims records must be maintained as part of the records of the insurer's operations and must be readily available to examiners. Notwithstanding the definition of "claim" at subsection 20 CSR 100-1.010(1)(B), the time *[requirements]* **standards** for the retention of records for policy files stated at section 374.205.2(2), RSMo, apply to claims handled by the company's personnel who typically handle policy files;

(D) The Missouri complaint records *[required to be]* maintained *[under]* **pursuant to** section 375.936(3), RSMo**,** shall include **the actual written complaints, the insurer's responses and any materials referenced in an insurer's response that are not otherwise maintained by the insurer, along with** a complaint log or register *[in addition to the actual written complaints. The complaint log or register shall]* **that** shows clearly the total number of complaints for a period of not less than the immediately preceding three (3) years, the classification of each complaint by line of insurance, the nature of each complaint, *[and]* the disposition of each complaint*[. The complaint log or register shall contain]***, and** a reference to the location of the file to which each complaint corresponds. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating such documentation shall be an identifier such as the policy number or other code*[. Such codes shall]***, and an identifier key will** be provided to the examiners at the time of an examination; and

(E) The insurer shall retain declined underwriting files for a period of three (3) years from the date of declination. The term "declined underwriting file" *[shall]* mean**s** all written or electronic records concerning a policy for which an application for insurance coverage has been completed and submitted to the insurer or its insurance producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested. A declined underwriting file shall include an application, any documentation substantiating the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation substantiating the decision not to add additional coverage when requested, and, if required by law, any declination notification. Notes regarding requests for quotations which do not result in a completed application for coverage need not be maintained for purposes of this regulation.

(4) Form of Record.

(A) Any record *[required]* to be maintained by an insurer **pursuant to Missouri law**, may be in the form of paper; photograph; computer; magnetic, mechanical, or electronic medium; or any process which accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document. Documents *[that require]* **necessitating** the signature(s) of the insured and/or insurer's insurance producer, shall be maintained in any format as listed above provided evidence of the signature(s) is preserved in that format.

[(B) The maintenance of records in a computer-based format shall be archival in nature only, so as to preclude, to the extent reasonable, the alteration of the record after the initial transfer to a computer format. Upon request of an examiner, all records shall be capable of duplication to a hard copy that is as legible as the original document. Such records shall be maintained according to written procedures developed and adhered to by the insurer. Said written procedures shall be made available to the department's market conduct examiners in accordance with section (6) below.]

(B) Once a record has been finalized, either for internal or external transmission or for file documentation purposes, or once an electronic record or database is finalized for permanent retention purposes, it shall be maintained in a computer-based format that is archival in nature, so as to preclude any alteration of the record after the initial transfer to archival format. All records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available upon examiner request.

(C) Photographs, microfilms**,** or other image-processing reproductions of records *[shall be]* **are deemed the** equivalent *[to]***of** the originals and may be certified as the same in actions or proceedings before the department unless inconsistent with 20 CSR 800-1.100.

(5) Location of Files. All records *[required]* to be maintained *[under this rule]* **by an insurer pursuant to Missouri law** shall be kept in a location which will allow the records to be produced for examination within the time period *[required]* **set out** under section (6) of this rule. When, under normal circumstances, someone other than the insurer maintains a *[required]* record or type of record, the other person's or entity's responsibility to maintain the records shall be set forth in a written agreement, **with** a copy *[of which shall be]* maintained by the insurer and *[shall be]* **made** available to the examiners for purposes of examination.

(6) Time Limits to Provide Records and to Respond to Examiners.

(A) **Pursuant to section 374.205.2(2), RSMo,** *[A]***a**n insurer shall provide any record requested by any examiner within ten (10) calendar days. When the requested record is not or cannot be produced by the insurer within ten (10) calendar days, this nonproduction *[shall be]* **is** deemed a violation of **section 374.205.2(2), RSMo, and** this rule, unless the insurer can demonstrate to the satisfaction of the director that the requested record cannot reasonably be provided within ten (10) calendar days of the request.

(B) As a means to facilitate the examination and to aid in the examination in accordance with section 374.205.2(2), RSMo, an insurer shall provide a written response to any inquiry submitted by any examiner within ten (10) calendar days. When the requested information is not provided by the insurer within ten (10) calendar days, a violation *[shall be]* **is** deemed to have occurred, unless the insurer can demonstrate to the satisfaction of the director that the requested response cannot reasonably be provided within ten (10) calendar days of the inquiry.

(7) Examination Work Papers. Records *[required to be]* provided during a market conduct examination *[shall]* **will** be returned to the insurer following the examination, unless such records relate to an inquiry made by a department examiner. Records related to an inquiry *[shall]* become a part of the work papers of the examination. **Section 374.205, RSMo, and** *[R]***r**egulation 20 CSR 10-2.400 *[shall]* govern the public access to the work papers of the examination.

AUTHORITY: sections ***374.045, 374.205, 374.207, and*** *375.948, RSMo [2000 and section 374.045, SB 788, 94th General Assembly, Second Regular Session, 2008]* ***2016****. Original rule filed Nov. 1, 2007, effective July 30, 2008. Emergency amendment filed June 23, 2008, effective July 30, 2008, expired Feb. 26, 2009. Amended: Filed June 23, 2008, effective Jan. 30, 2009. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 17—Admissions

PROPOSED AMENDMENT

20 CSR 200-17.100 Procedure for Forming a Missouri Domestic Insurance Company. The director is amending sections (1) and (2).

PURPOSE: This amendment removes outdated language and updates the rule to reflect the modern procedure for forming a Missouri domestic insurance company.

(1) The procedures outlined in section (2) of this rule are the procedures *[required]* for the successful formation of a Missouri domestic insurance company authorized to transact an insurance business in this state. The steps outlined in subsections (A) through *[(E)]* **(F)** of section (2) are set forth in *[the required]* chronological order *[beginning with the first step]*.

(2) A Missouri domestic insurance company shall be formed in accordance with the following procedures and forms:

(A) The incorporators form the corporation that will become an insurance company organized under the laws of the state of Missouri. The incorporators must:

1. Issue a declaration of intent to form an insurance company and state its articles of incorporation to comply with the requirements of Missouri law. See sections 376.010 to 376.120, RSMo (life insurance companies) and sections 379.010 to 379.065, RSMo (other than life). Particular attention should be paid to the requirements for the number and residence of the members of the board of directors and the place where the principal office for the conduct of the insurance company's business will be conducted. *[Such place must be stated with sufficient specificity so that an examiner can verify that in fact the insurance company's principal business will be located at the address stated]* **Prior to publication, the company is encouraged to provide a draft of the declaration and articles of incorporation to the Division of Insurance Company Regulation (division) of the department for review**;

2. Publish the declaration and the articles *[as required by]* **pursuant to** law; and

3. File with the *[Division of Financial Regulation (DFR) of the Missouri Department of Insurance (MDI)]* **division** an affidavit of publication from the publisher of the declaration and articles, and the articles in triplicate original; **and**

4. Submit to the division a completed Uniform Certificate of Authority Application (UCAA)-primary application. Upon request, the division will provide information regarding—

A. How to obtain the appropriate UCAA form (including any forms specific to Missouri under the UCAA review process); and

B. The application of the statutory standards for evaluating an application for a certificate of authority;

(B) If the *[insurance]* company's filings under paragraph 3**.** of subsection (A) are in compliance with the applicable laws and regulations relating to a Missouri domestic insurance company, the *[DFR]* **division** will cause the articles to be reviewed by the Missouri attorney general (AG). Upon receipt of the AG's certification, the *[DFR]* **department** will file the articles and a copy of the AG's certification with the Missouri secretary of state for the issuance of a certificate of incorporation. (The secretary of state may require the payment of certain fees and taxes before issuing the certificate of incorporation);

(C) Upon receipt of a copy of the certificate of incorporation, the company shall:

1. Form its board of directors, appoint officers, issue stock (if a stock company) or take deposits (if a mutual company); **and**

2. Place the proceeds from the stock subscription or deposits into accounts (including the deposit with *[Department of Insurance]* **the department**);

[3. File with the MDI's Property and Casualty Section or the Life and Health Section (whichever is applicable) any premium rates, policy forms or endorsements as may be needed to transact the insurance company's business; and

4. Submit to the DFR a completed Uniform Certificate of Authority Application (UCAA)—primary application. Upon request, the DFR will provide information regarding:

A. How to obtain the appropriate UCAA form (including any forms specific to Missouri under the UCAA review process); and

B. The application of the statutory standards for evaluating an application for a certificate of authority;

(D) Upon notice from the company that the steps listed in subsection (C) have been completed, the DFR will contact the insurance company to schedule a pre-licensing examination. Among other things, the examination will verify the statutory deposit, compliance with financial requirements, the location of the insurance company's principal place of business, the filing of any necessary policy or endorsement forms, and the competency and integrity of the insurance company's officers and directors; and

(E) Based upon the recommendation in the report of the pre-licensing examination, the DFR will cause the completion of the formation process. Formation is complete upon the issuance by the director of the MDI of a certificate of authority to transact the business of insurance in this state.]

(D) The division may contact the company to schedule a pre-licensing examination, which may, among other things, verify the statutory deposit, compliance with financial requirements, the location of the company's principal place of business, and the competency and integrity of the company's officers and directors;

(E) Upon receipt of a copy of the certificate of incorporation and notice from the division of the completion of its review of the application, the director will determine whether or not to issue a certificate of authority to transact the business of insurance in this state; and

(F) Upon receipt of a certificate of authority, the insurance company will file with the department's Property and Casualty Section or Life and Health Section (whichever is applicable) any premium rates, policy forms or endorsements as may be needed to transact the insurance company's business.

*AUTHORITY: section 374.045, RSMo [2000] **2016**. Original rule filed June 14, 2001, effective Dec. 30, 2001. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for July 18, 2019 at 9 a.m. at 301 W. High, Room 530, Jefferson City, MO 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 17—Admissions

PROPOSED AMENDMENT

20 CSR 200-17.300 Procedure for Redomestication. The director is amending sections (1) and (2).

PURPOSE: This amendment removes outdated language and updates the rule to reflect the modern procedure for redomesticating an insurance company to or from Missouri.

(1) Redomestication to Missouri from Another State. In order to redomesticate an insurance company organized under the laws of any other state to the state of Missouri, the insurance company shall comply with the following forms and procedures in the chronological order set forth below beginning with subsection (A)*[:]***. The insurance company must—**

(A) *[The insurance company must obtain]* **Obtain** a certificate of authority to transact an insurance business in the state of Missouri, if not previously obtained;

(B) *[The insurance company must obtain]* **Obtain** the approval of the current state of domicile to redomesticate to Missouri. This approval may be either unconditional or conditioned on future events such as Missouri's acceptance of the redomestication;

(C) *[The insurance company must apply]* **Apply** for redomestication to Missouri. The law (section 375.908, RSMo) requires a company redomesticating to Missouri to comply with all the requirements of law relative to organizing and licensing a domestic insurer. This means that the company must*[:]*—

1. Submit to the Division of Insurance Company Regulation (division) of the department a completed Uniform Certificate of Authority Application (UCAA)-primary application;

*[1.]***2.** *[Locate]* **Designate** its principal place of business at a place in Missouri;

*[2.]***3.** Issue a declaration and amend and restate its articles of incorporation to comply with the requirements of Missouri law. See sections 376.010 to 376.120, RSMo (life insurance companies) and 379.010 to 379.065, RSMo (other than life). A declaration of intent to redomesticate will be accepted as a substitute for a declaration of intent to form. The amended and restated articles will be accepted as a substitute for the charter. The **quantity of** directors **referenced in section 376.060, 376.100, 379.035, or 379.060, RSMo, as applicable,** will be *[acceptable]* **accepted as** substitutes for the incorporators**. Prior to publication, the insurance company is encouraged to provide a draft of the declaration and articles of incorporation to the division for review**;

*[3.]***4.** Publish the declaration and the amended and restated articles *[as required by]* **pursuant to** law. The declaration may reflect the intent to redomesticate rather than the intent to form; **and**

4. File with the *[Division of Financial Regulation (DFR) of the Missouri Department of Insurance (MDI)]* **division** an affidavit of publication from the publisher of the amended and restated articles, the amended and restated articles in triplicate original, **and** the order from the current state of domicile approving the redomestication*[, and an application for an amended certificate of authority (which will state among other things, the location of the principal place of business); and]* **or other evidence of approval acceptable to the director;**

[5. File with the MDI's Property and Casualty Section or the Life and Health Section (whichever is applicable) any amended policy forms or endorsements as may be needed to reflect Missouri as the insurance company's state of domicile;]

(D) If the insurance company's filings are in compliance with the applicable laws and regulations relating to a Missouri domestic insurance company, the *[DFR]* **division** will cause the articles to be reviewed by the Missouri attorney general (AG). Upon receipt of the AG's certification, the *[DFR]* **department** will file the articles and a copy of the AG's certification with the Missouri secretary of state for the issuance of a certificate of incorporation. (The secretary of state may require the payment of certain fees and taxes before issuing the certificate of incorporation);

(E) The division may contact the company to schedule a pre-licensing examination, which may, among other things, verify the statutory deposit, compliance with financial requirements, the location of the company's principal place of business, and the competency and integrity of the company's officers and directors; and

*[(E)]***(F)** Upon receipt of the certificate of incorporation, *[the DFR will contact the insurance company to schedule a pre-licensing examination. The scope of this examination will vary depending on the circumstances, including the extent and as of date of the insurance company's most recent examination. Among other things, the examination will verify the statutory deposit, compliance with financial requirements, the location of the insurance company's principal place of business, the filing of any necessary policy or endorsement forms, and the competency and integrity of the insurance company's officers and directors; and]* **and notice from the division of the completion of its review of the application, the director will determine whether or not to issue a certificate of authority to transact the business of insurance in this state as a domestic insurance company.**

[(F) Based upon the recommendation in the report of the pre-licensing examination, the DFR will cause the completion of the redomestication process. Redomestication is complete upon the issuance by the director of the MDI of a certificate of authority amended to reflect Missouri as the insurance company's state of domicile.]

(2) Redomestication from Missouri to Another State. In order to redomesticate an insurance company organized under the laws of the state of Missouri to another state, the insurance company shall comply with the following forms and procedures in the chronological order set forth below beginning with subsection (A):

(A) The Missouri domestic insurer must request the *[DFR]* **division** to approve a redomestication to a specified state and provide evidence that the Missouri domestic insurer is admitted to do business in that state. The *[DFR]* **division** will then *[cause the MDI to]* **recommend that the director** issue a contingent approval and state the terms for finalizing the redomestication and making the contingent approval absolute.

(B) After receipt of the contingent approval, the insurance company shall obtain and file each of the following:

1. A certified copy of the state's order approving the redomestication**, or other evidence of approval acceptable to the director**;

2. An application to amend certificate of authority *[(form enclosed)]***, available on the department's website or by contacting the division**;

3. A certified copy of amended or restated articles of incorporation from new state of domicile;

4. A certified copy of certificate of authority from new state of domicile;

5. An appointment of the director *[of the MDI]* as agent for receipt of service of process; and

6. The filing fee for amending the Missouri certificate of authority.

(C) The *[DFR will cause the MDI to]* **director will** make the contingent approval absolute after the insurer files all items described under subsection (B) of this section.

*AUTHORITY: section 374.045, RSMo [2000] **2016**. Original rule filed June 14, 2001, effective Dec. 30, 2001. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for July 18, 2019 at 9 a.m. at 301 W. High, Room 530, Jefferson City, MO 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 20—Captive Insurance Companies

PROPOSED AMENDMENT

20 CSR 200-20.040 Financial Requirements. The director is amending sections (1)-(7).

PURPOSE: This amendment clarifies the rule and relaxes certain restrictions.

(1) Annual Reporting Requirements.

(A) An association captive insurance company doing business in this state shall annually submit to the director a report of its financial condition, verified by oath of two (2) of its executive officers. The report shall be *[that required by]* **prepared in accordance with** section 375.041, RSMo.

(C) A special purpose life reinsurance captive (SPLRC) doing business in this state shall annually submit on or before March 1 of each year a report of its financial condition, verified by oath of two (2) of its executive officers. The report shall be *[that required by]* **prepared in accordance with** section 375.041, RSMo.

(2) Annual Audit. All companies shall have an annual audit by an independent certified public accountant (CPA), except to the extent waived by the director. The company shall within ninety (90) days of admission apply to the director for approval of the CPA by submitting an application to the director (Form CI-3). *[Each company shall file an]* **Annual** audited financial report**s** *[with]* **are due to** the director on or before June 30 (except for SPLRCs, *[which shall file]* **whose filings are due** on or before May 31) for the year ending December 31 immediately preceding, unless the director has approved a fiscal year ending on a date other than December 31 in which case the audited financial report shall be filed with the director within six (6) months after the end of such approved fiscal year. The annual audit report *[shall]* **will** be considered part of the company's annual report of financial condition except with respect to the **filing due** date *[by which it must be filed with the director]*. The annual audit shall consist of the following:

(A) Opinion of Independent Certified Public Accountant. Financial statements furnished pursuant to this section shall be examined by independent certified public accountants in accordance with

generally accepted auditing standards as determined by the American Institute of Certified Public Accountants. The opinion of the independent certified public accountant shall cover all years presented**,** *[. The opinion shall]* be addressed to the company on stationery of the accountant showing the address of issuance, *[shall]* bear *[original manual]* signatures**,** and *[shall]* be dated;

(B) Report of Evaluation of Internal Controls. This report shall include an evaluation of the internal controls of the company relating to the methods and procedures used in the securing of assets and the reliability of the financial records, including but not limited to such controls as the system of authorization and approval and the separation of duties. *[The]* **Unless otherwise approved by the director, the** review *[shall]* **will** be conducted in accordance with generally accepted auditing standards;

(D) Financial Statements. *[Statements required]* **Included financial statements** shall be as follows:

1. Balance sheet;
2. Statement of gain or loss from operations;
3. Statement of changes in financial position;
4. Statement of changes in capital paid up, gross paid in and contributed surplus and unassigned funds (surplus); and
5. *[Notes]* **Unless otherwise approved by the director, notes** to financial statements*[, which shall be those]* required by generally accepted accounting principles, *[and shall include]* **including**:

A. A reconciliation of differences, if any, between the audited financial report and the statement or form filed with the director;

B. A summary of ownership and relationship of the company and all affiliated corporations or companies insured by the captive; and

C. A narrative explanation of all material transactions and balances with the company; and

(E) Actuarial Certification. The annual audit shall include an opinion as to the adequacy of the company's loss reserves and loss expense reserves. The individual who certifies as to the adequacy of reserves shall be a member in good standing of the American Academy of Actuaries and *[shall]* apply to the director for approval by submitting an application to the director (Form CI-4). As to any SPLRC or any company providing life insurance or annuity contracts, such certification shall include the opinion *[required by]* **detailed in** section 376.380, RSMo.

(3) Availability and Maintenance of Work*[ing]* Papers of the Independent Certified Public Accountant. Each company shall require the independent certified public accountant to make available for review **and photocopying** by the director or the director's appointed agent the work papers prepared in the conduct of the audit of the company. The company shall require that the accountant retain the audit work papers for a period of not less than five (5) years after the period reported upon. The aforementioned review by the director *[shall be considered]* **is** an *[investigation]* **examination** and all work*[ing]* papers obtained during the course of such *[investigation shall be]* **examination are** confidential. *[The company shall require that the independent certified public accountant provide photocopies of any of the working papers which the director considers relevant.]* Such work*[ing]* papers may be retained by the department. "Work papers" as referred to in this section include, but are not necessarily limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and the accountant's employees in the conduct of their examination of the company.

(4) Notification of Adverse Financial Condition. A company shall require the certified public accountant to immediately notify in writing an officer and all members of the board of directors of the company of any determination by the independent certified public accountant that the company has materially misstated its financial condition in its report to the director *[as required in]* **pursuant to** section 379.1312 or 379.1403, RSMo. The company *[shall]* **will** furnish such notification to the director within five (5) working days of receipt thereof.

(5) Deposit Requirement. Whenever the director deems that the financial condition of the company warrants additional security, the director may require a company to deposit with the director in a depository chosen by the director cash or securities approved by the director or, alternatively, to furnish the director a clean irrevocable letter of credit issued by a bank chartered by the State of Missouri or a member bank of the Federal Reserve System and approved by the director (Form CI-2). The company may receive interest or dividends from said deposit or exchange the deposits for others of equal value with the approval of the director. If such company discontinues business, the director *[shall]* **will** return such deposit only after being satisfied that all obligations of the company have been discharged.

(6) Reinsurance.

(A) Any company authorized to do business in this state may take credit for reserves on risks ceded to a reinsurer subject to the following limitations**. No credit shall be allowed***[:]***—**

1. *[No credit shall be allowed for]* **For** reinsurance where the reinsurance contract does not result in the complete transfer of the risk or liability to the reinsurer with respect to the portion of the liability purported to be reinsured; and
2. *[No credit shall be allowed, as]* **As** an asset or a deduction from liability, to any ceding insurer for reinsurance unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract reinsured without diminution because of the insolvency of the ceding insurer;

(B) Reinsurance under this section *[shall]* **is to** be effected through a written agreement of reinsurance setting forth the terms, provisions and conditions governing such reinsurance; and

(C) The director in his discretion may require that complete copies of all reinsurance treaties and contracts be filed and/or approved by him.

(7) Premium Tax.

(A) On or before February 1 of each year, each company shall file a premium tax return (Form CI-5) on a form provided by the director with respect to its direct premiums written and reinsurance assumed premiums written for the year ending the preceding December 31. *[The tax upon such premiums shall be according to the rates provided by law and shall be subject to the minimum and maximum taxes provided by law. Notwithstanding such minimum and maximum taxes, each company may deduct the application and license and license renewal fees from the taxes payable; provided that such deductions shall be the only deductions from the taxes otherwise payable.]*

(B) On or before March 31 of each year, the director *[shall]* **will** certify to the director of revenue the taxes payable by each company.

(D) *[Each company shall pay the taxes assessed]* **Payment of taxes assessed is due** to the director of revenue on or before May 1.

*AUTHORITY: sections 374.045, [RSMo 2000 and sections] 379.1328, and 379.1421, RSMo [Supp. 2007] **2016**. Original rule filed Nov. 15, 2007, effective June 30, 2008. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for July 18, 2019 at 9 a.m. at 301 W. High, Room 530, Jefferson City, MO 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

PROPOSED AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The director is amending sections (1), (3), (8), and (9); adding a new section (10); re-numbering subsequent sections; correcting intersectional references; deleting the chart titled "Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010" and replacing it with a chart titled, "Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020"; deleting the chart titled "Plan F or High Deductible Plan F" and replacing it with a new chart with the same title; and deleting the chart titled "Plan G" and replacing it with a new chart titled "Plan G or High Deductible Plan G." All other charts remain unchanged.

PURPOSE: This amendment makes changes to Missouri's rules related to Medicare Supplement policies that are consistent with changes made by Congress when it enacted the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) in 2015. MACRA made changes to Medicare Supplement policies that cover Part B deductibles for individuals newly eligible for Medicare on or after January 1, 2020. This proposed amendment makes changes to the current Medicare Supplement regulation to specify that first dollar Part B coverage Medicare Supplement plans (Plans C, F, and F High Deductible) cannot be sold to individuals newly eligible for Medicare on or after January 1, 2020. It also makes Plans D and G the guarantee issue plans for individuals who are newly eligible for Medicare on or after January 1, 2020. Finally, it reflects the newly-created Plan G High Deductible option.

(1) Applicability and Scope.

(A) Except as otherwise specifically provided in sections (5), *[(12), (13), (16), and (23)]* **(13), (14), (17), and (24)**, this rule shall apply to—

1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means, for purposes of section *[(14)]* **(15)**, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(8) Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in paragraph (6)(C)11. and in section *[(10)]* **(11)** of this rule.

(9) Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates with an Effective Date for Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A) ***Reserved***

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (7)(B) of this regulation.

2. If an issuer makes available any of the additional benefits described in subsection (7)(C), or offers standardized benefit Plans K or L (as described in paragraphs (9)(E)8. and 9. of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to the basic (core) benefits as described in paragraph (9)(A)1. above, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (9)(E)3. of this regulation) or standardized benefit Plan F (as described in paragraph (9)(E)5. of this regulation).

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection (9)(F) and in *[section (10)]* **sections (10) and (11)** of this regulation.

(E) Make-up of 2010 Standardized Benefit Plans.

1. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (7)(B) of this regulation.

2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in paragraph (7)(C)1. of this regulation.

3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., and 6. of this regulation, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in subsection (7)(B) of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6. of this regulation, respectively.

5. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as

defined in paragraphs (7)(C)1., 2., 4., 5., and 6., respectively.

6. Standardized Medicare supplement Plan F With High Deductible shall include only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (9)(E)6.B.

A. The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., 5., and 6., of this regulation, respectively.

B. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars ($1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve- (12-)*[-]* month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

7. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 5., and 6., respectively. **Effective January 1, 2020, the standardized benefit plan described in paragraph (10)(A)4. of this rule (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.**

8. Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Part A Hospital Coinsurance ninety-first through the one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

C. Part A Hospitalization After One Hundred Fifty (150) Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

E. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

F. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

G. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

H. Part B Cost Sharing: Except for coverage provided in subparagraph (9)(E)8.I., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

I. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. The benefits described in subparagraphs (9)(E)8.A., B., C., and I.;

B. The benefit described in subparagraphs (9)(E)8.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (9)(E)8.J, but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

10. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)2., 3., and 6. of this regulation, respectively.11. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6., of this regulation, respectively, with copayments in the following amounts:

A. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

B. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(10) Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or

after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of section (9) of this rule.

(A) Benefit Requirements. The standards and requirements of section (9) shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

1. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in paragraph (9)(E)3. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible;

2. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in paragraph (9)(E)5. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible;

3. Standardized Medicare supplement benefit Plan C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020;

4. Standardized Medicare supplement benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in paragraph (9)(E)6. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible; and

5. The reference to Plans C or F contained in paragraph (9)(A)2. is deemed a reference to Plans D or G for purposes of this section (10).

(B) Applicability to Certain Individuals. This section (10) applies only to individuals that are newly eligible for Medicare on or after January 1, 2020—

1. By reason of attaining age 65 on or after January 1, 2020; or

2. By reason of entitlement to benefits under Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(C) Guaranteed Issue for Eligible Persons. For purposes of subsection (13)(E) of this rule, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) shall be deemed to be a reference to Medicare supplement Policy D or G (including G with High Deductible) respectively that meets the requirements of this section (10).

(D) Offer of Redesignated Plans to Individuals other than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in paragraph (A)4. of this section (10) may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in subsection (9)(E) of this rule.

*[(10)]***(11)** Medicare Select Policies and Certificates.

(A) ***Reserved***

1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(B) For the purposes of this section—

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers;

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers;

3. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate;

4. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions;

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy;

6. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers; and

7. "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

(C) The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the director finds that the issuer has satisfied all of the requirements of this rule.

(D) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

(E) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

A. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

B. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either—

(I) To deliver adequately all services that are subject to a restricted network provision; or

(II) To make appropriate referrals;

C. There are written agreements with network providers describing specific responsibilities;

D. Emergency care is available twenty-four (24) hours per day and seven (7) days per week; and

E. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate;

2. A statement or map providing a clear description of the service area;

3. A description of the grievance procedure to be utilized;

4. A description of the quality assurance program, including:

A. The formal organizational structure;

B. The written criteria for selection, retention, and removal of network providers; and

C. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

5. A list and description, by specialty, of the network providers;

6. Copies of the written information proposed to be used by the

issuer to comply with subsection (I) of this section; and

7. Any other information requested by the director.

(F) ***Reserved***

1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the director at least quarterly.

(G) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if—

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

2. It is not reasonable to obtain services through a network provider.

(H) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(I) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L";

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(J) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (I) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(K) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March thirty-first to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(L) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(M) ***Reserved***

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(O) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

*[(11)]***(12)** Open Enrollment.

(A) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six**-** (6**-**)*[-]* month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(B) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in

this state, nor discriminate in the pricing of that policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant under age sixty-five (65), if:

1. The application for the policy or certificate is submitted prior to or during the six- (6-)*[-]* month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age, after June 30, 1998; or

2. The applicant was enrolled for benefits under Medicare Part B without regard to age on or prior to June 30, 1998, and the application for a policy or certificate is submitted during the six- (6-)*[-]* month period beginning with June 30, 1998.

(C) ***Reserved***

1. If an applicant qualifies under either subsection *[(11)]***(12)**(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under either subsection *[(11)]***(12)**(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(D) Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare supplement insurance under this section.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection *[(15)]***(16)**(D) by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(F) Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods described in subsection (B) of this section.

(G) No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in subsection (B) of this section:

1. Encouraging or directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care, or medical condition of the person; and

2. Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care, or medical condition of the person.

(H) No Medicare supplement carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an insurance producer that provides for or results in the compensation paid to an insurance producer for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care, or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an insurance producer, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an insurance producer for any reason related to the age, health status, claims experience, receipt of health care, or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the insurance producer with the Medicare supplement insurance carrier.

(K) Denial by a Medicare supplement insurance carrier of an application for coverage made during either of the open enrollment periods described in subsection (B) of this section shall be in writing and state the specific reason or reasons for the denial.

(L) Except as provided in subsection (C) of this section and section *[(23)]* **(24)**, subsections (A) and (B) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

*[(12)]***(13)** Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who seek to enroll under the policy during the period specified in subsection (C) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (E) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement

policy.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual, or the individual leaves the plan;

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

A. The certification of the organization or plan has been terminated;

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

C. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

D. The individual demonstrates, in accordance with guidelines established by the secretary, that—

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, insurance producer, or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual; or

E. The individual meets such other exceptional conditions as the secretary may provide;

3. ***Reserved***

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999

(III) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph *[(12)]***(13)**(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A. ***Reserved***

(I) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, insurance producer, or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual;

5. ***Reserved***

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph *[(12)]***(13)**(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment;

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

8. Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: *[(]*i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or *[(]*ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter*[;]***.**

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5., or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated*[;]***.**

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: *[(]*i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and *[(]*ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated*[;]***.**

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B. or (B)4.C., or paragraph (B)5. or (B)6. of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date*[;]***.**

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D*[; and]***.**

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days

after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph *[(12)]***(13)**(B)5.*[; and]*

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph *[(12)]***(13)**(B)6.*[; and]*

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two-(2-)*[-]* year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(E) Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs *[(12)]***(13)**(B)1., 2., 3., and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer;

2. ***Reserved***

A. Subject to subparagraph B., paragraph *[(12)]***(13)**(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is*[:]*—

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K, or L policy that is offered by any issuer;

3. Paragraph *[(12)]***(13)**(B)6. shall include any Medicare supplement policy offered by any issuer;

4. Paragraph *[(12)]***(13)**(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

5. Paragraph *[(12)]***(13)**(B)8. shall include any Medicare supplement policy offered by any issuer, but only a policy of the same plan as the coverage in which the individual was most recently enrolled, if available, or, if not so available due to changes in the Medicare supplement plan designs, a policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L.

(F) Notification Provisions.

1. At the time of an event described in subsection (B) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

*[(13)]***(14)** Standards for Claims Payment.

(A) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, P.L. No. 100-203) by—

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise; and

6. Providing to the secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(B) Compliance with the requirements set forth in subsection (A) above shall be certified on the Medicare supplement insurance experience reporting form.

*[(14)]***(15)** Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1. ***Reserved***

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that

expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For purposes of applying paragraph (A)1. of this section and paragraph (C)3. of section *[(15)]* **(16)** only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with January 1, 2006, to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A, included herein, for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 2006. The first report shall be due by May 31, 2008.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen- (13-)*[-]* week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

1. ***Reserved***

A. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

B. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section*[.]***;**

2. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(D) Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of April 8, 1993, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

*[(15)]***(16)** Filing and Approval of Policies and Certificates and Premium Rates.

(A) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements prescribed by the director.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

(C) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(D) ***Reserved***

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or insurance producer marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(E) ***Reserved***

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

A. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

B. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph *[(15)]***(16)**(H)11. The director may approve a change to the differential which is in the public interest.

(F) ***Reserved***

1. Except as provided in paragraph (F)2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section *[(14)]***(15)** of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(G) ***Reserved***

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph *[(15)]***(16)**(E)3. If the policy forms or certificate forms were at any time approved by the director under an issue-age methodology, the issuer must use the most recently approved issue-age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under *[(15)]***(16)**(E)3.

(H) Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection *[(14)]***(15)**(C) or a change of premium rates for a plan under subsection *[(15)]***(16)**(C), the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which can be accessed at the department's website at www.insurance.mo.gov.;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio, and life-years. The durational split may be either by policy or certificate duration, calendar duration, or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios, and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph (H)3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection *[(15)]***(16)**(D) for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection *[(11)]***(12)**(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph *[(11)]***(12)**(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection *[(15)]***(16)**(D).

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule, and supporting documentation required to be filed under subsection (H) of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection *[(14)]***(15)**(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection *[(14)]***(15)**(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

*[(16)]***(17)** Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(C) No issuer or other entity shall provide compensation to its insurance producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(D) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

*[(17)]***(18)** Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6. ***Reserved***

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services (CMS) and in a type size no smaller than twelve- (12-)*[-]* point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers,

delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall—

A. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

B. Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve**-** (12**-**)*[-]* point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

[**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011.)

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance.**

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance *		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: a √ means 100% of the benefit is paid.

	Plans available to All Applicants								Medicare first eligible before 2020 only	
Benefits	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurance or Copayment	√	√	√	√	50%	75%	√	√ copays apply[3]	√	√
Blood (first three pints)	√	√	√	√	50%	75%	√	√	√	√
Part A hospice care coinsurance or copayment	√	√	√	√	50%	75%	√	√	√	√
Skilled nursing facility coinsurance			√	√	50%	75%	√	√	√	√
Medicare Part A deductible		√	√	√	50%	75%	50%	√	√	√
Medicare Part B deductible									√	√
Medicare Part B excess charges				√						√
Foreign travel emergency (up to plan limits)			√	√			√	√	√	√
Out-of-pocket limit in [2019][2]					[$5,560][2]	[$2,780][2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of [$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1364]	$[1364] (Part A deductible)	$0
61st thru 90th day	All but $[341] a day	$[341] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[682] a day	$[682] a day	$0
Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[170.50] a day	Up to $[170.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[185] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[185] of Medicare-approved amounts*	$0	$[185] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0

Part B excess charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[185] of Medicare-approved amounts*	$0	$[185] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2300] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2300] DEDUCTIBLE, ** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[185] of Medicare-approved amounts*	$0	$[185] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2300] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2300] DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2300] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [$2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1364]	$[1364] (Part A deductible)	$0
61st thru 90th day	All but $[341] a day	$[341] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[682] a day	$[682] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE, **] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[170.50] a day	Up to $[170.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[185] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2300] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [$2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not included the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUTCIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE, **] YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[185] of Medicare-approved amounts*	$0	$0	$[185] (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUTCIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE, **] YOU PAY
BLOOD			
First 3 pints	$0	All costs	$0
Next $[185] of Medicare-approved amounts*	$0	$0	$[185] (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2300] DEDUTCIBLE,**] PLAN PAYS	[IN ADDITION TO $[2300] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[185] of Medicare-approved amounts*	$0	$0	$[185] (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(E) Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve- (12-)*[-]* point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph (E)1. of this section shall disclose, using the applicable statement in Appendix C, included herein, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

*[(18)]***(19)** Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.

Statements:

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions:

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1)

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spenddown Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)

(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)

(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____
_____
_____
_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START __/__/__ END __/__/__

(B) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(C) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the insurance producer, except where the coverage is sold without an insurance producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection *[(18)]***(19)**(D) above for an issuer shall be provided in substantially the following form in no less than twelve- (12-)*[-]* point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application**] [**information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER [OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____Disenrollment from a MedicareAdvantage plan. Please explain reason for disenrollment (optional only for Direct Mailers)

_____
_____
_____

____ Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Insurance Producer or Other Representative)*

[Typed Name and Address of Issuer, Insurance Producer]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

(F) Paragraphs 1. and 2. of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

*[(19)]***(20)** Filing Requirements for Advertising. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law.

*[(20)]***(21)** Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its insurance producers will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp, or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**;

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

(B) In addition to the practices prohibited in the Unfair Trade Practices Act (sections 375.930 to 375.948, RSMo) and the Unfair Claim Settlement Practices Act (sections 375.1000 to 375.1018, RSMo), the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(C) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around," and words of similar import shall not be used unless the policy is issued in compliance with this rule.

*[(21)]***(22)** Appropriateness of Recommended Purchase and Excessive Insurance.

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an insurance producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(B) Any sale of Medicare supplement coverage that will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited.

(C) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

*[(22)]***(23)** Reporting of Multiple Policies.

(A) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate:

1. Policy and certificate number; and

2. Date of issuance.

(B) The items set forth above must be grouped by individual policyholder.

*[(23)]***(24)** Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates.

(A) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(B) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

*[(24)]***(25)** Prohibition Against Use of Genetic Information and Requests for Genetic Testing. This section applies to all policies with policy years beginning on or after May 21, 2009.

(A) An issuer of a Medicare supplement policy or certificate—

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(B) Nothing in subsection *[(24)]***(25)**(A) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from—

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one **(1)** individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(C) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(D) Subsection *[(24)]***(25)**(C) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time-to-time) and consistent with subsection *[(24)]* **(25)**(A).

(E) For purposes of carrying out subsection *[(24)]***(25)**(D), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(F) Notwithstanding subsection *[(24)]***(25)**(C), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

2. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—

A. Compliance with the request is voluntary; and

B. Non-compliance will have no effect on enrollment status or premium or contribution amounts;

3. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

4. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

5. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

(G) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(H) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(I) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection *[(24)]***(25)**(H) if such request, requirement, or purchase is not in violation of subsection *[(24)]***(25)**(G).

(J) For the purposes of this section only:

1. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer;

2. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

3. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt

of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual;

4. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education;

5. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved; and

6. "Underwriting purposes" means—

A. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

B. The computation of premium or contribution amounts under the policy;

C. The application of any pre-existing condition exclusion under the policy; and

D. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

*[(25)]***(26)** Separability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

AUTHORITY: section 374.045, ***376.864, 376.869, and 376.886*** *RSMo [Supp. 2009]* ***2016****. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expired Feb. 2, 2006. Amended: Filed May 16, 2005, effective Nov. 30, 2005. Emergency amendment filed June 19, 2009, effective July 1, 2009, expired Feb. 25, 2010. Amended: Filed Aug. 3, 2009, effective March 30, 2010. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will cost the Department of Insurance, Financial Institutions and Professional Registration less than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities ten thousand six hundred and fifty dollars ($10,650) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO. To be considered, comments must be received within thirty (30) days of publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 a.m. on July 18, 2019, at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri.*

SPECIAL NEEDS: If you have any special needs addressed by the Americans with Disabilities Act, please notify us at (573)751-2619 at least five (5) working days prior to the hearing.

FISCAL NOTE
PRIVATE COST

I. Department Title: Insurance, Financial Institutions and Professional Registration
Division Title: Life, Annuities and Health
Chapter Title: Medicare Supplement Insurance

Rule Number and Title:	20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
52	**Medicare Supplement Carriers filing a new outline of coverage document**	**$7,800**
19	**Medicare Supplement Carriers currently selling High Deductible Plan F that may file to sell new High Deductible Plan G**	**$2,850**

III. WORKSHEET

Number of Carriers	Category	Cost of Filing (number x $150)
52	**Carriers filing new outline of coverage**	**$7,800**
19	**Carriers filing to sell new High Deductible Plan G**	**$2,850**
TOTAL AGGREGATE COST		**$10,650**

IV. ASSUMPTIONS

The increase in costs to carriers to comply with this proposed amendment is limited to costs of new filings that will be made in the first year of implementation. We assume all 52 carriers currently writing business in the Medicare Supplement market will file new "Outlines of Coverage" in order to comply with this proposed amendment. After the new "Outline of Coverage" is filed in the first year, carriers will not be required to make additional new filings in order to comply with this proposed amendment. Medicare

Supplement carriers are required to make product filings with the Department on an annual basis, so after the first year, the carriers' annual product filings will satisfy the filing requirement with no additional filings necessary due to this proposed amendment.

There are currently 19 carriers offering High Deductible Plan F plans. The Department assumes that all 19 of these carriers will want to also offer High Deductible Plan G plans, resulting in new product filings for these carriers. As noted above, these 19 new filings represent one-time new filings and carriers will not have to make additional filings in subsequent years due to this proposed amendment.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 14—External Arbitration

PROPOSED RULE

20 CSR 400-14.100 External Arbitration

PURPOSE: This rule outlines the procedures by which the department will ensure access to binding arbitration when there is a dispute related to a claim for unanticipated out-of-network care and outlines the criteria for approved arbitrators. This rule is promulgated pursuant to sections 374.045 and 376.690, RSMo.

(1) When a health carrier or a health care professional provides written notification to the director and the other party of its intent to initiate arbitration proceedings pursuant to section 376.690.2(5), RSMo, the health carrier or health care professional shall provide the following information to the director:

(A) The name and contact information for the health carrier;

(B) The name and contact information for the out-of-network health care professional;

(C) The billed amount charged by the out-of-network health care professional for the service that is the subject of the dispute;

(D) The amount of the final offer made by each party, and the date the final offer was made;

(E) An attestation affirming that the information provided by the health carrier or health care professional is true and accurate; and

(F) Any additional information requested by the director.

(2) Prior to commencing arbitration proceedings pursuant to section 376.690.2(5), RSMo, a health care professional and a health carrier must demonstrate they have completed the negotiation period described in section 376.690.2(1)-(3), RSMo.

(3) The director shall publish on the department's website (www.insurance.mo.gov) a list of entities providing arbitration services.

(4) In order to qualify as a provider of arbitration services as described in section 376.690, RSMo, an entity or arbitrator must—

(A) Be currently engaged in arbitrating disputes between health carriers and health care professionals;

(B) Adhere to procedural rules outlined by the American Arbitration Association, the American Health Lawyers Association, or another entity with similar procedural rules, as determined by the director; and

(C) Have in place policies and procedures to avoid conflicts of interest.

(5) An arbitrator or entity seeking to be included on the list published by the department may submit such a request in writing to the director, outlining its qualifications. The director has sole discretion to determine whether or not to include an arbitrator or arbitration entity on the list published by the department, and may amend or revise the list from time-to-time as he or she deems necessary.

AUTHORITY: section 374.045, RSMo 2016, and section 376.690, RSMo Supp. 2018. Original rule filed May 13, 2019.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days of after publication of this notice in the Missouri Register. A public hearing is scheduled for 9:00 a.m. on July 18, 2019, at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri.

SPECIAL NEEDS: If you have any special needs addressed by the Americans with Disabilities Act, please notify us at (573)751-2619 at least five (5) working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 600—Statistical Reporting
Chapter 1—Reports Other Than Annual Statement and Credit Insurance

PROPOSED AMENDMENT

20 CSR 600-1.010 Medicare Supplement Data Reporting. The director is amending sections (1) and (2), deleting subsections (1)(A) and (1)(B), and deleting the forms which follow the rule as appendices in the *Code of State Regulations*.

PURPOSE: This proposed amendment clarifies and modernizes the rule by updating the forms utilized in reporting data.

(1) Medicare supplement loss data must be reported annually on or before April 1 of each year for the twelve (12) months ending December 31 next preceding *[on the forms which follow as appendices]* **on the Medicare Supplement Insurance Experience Report, available on the department's website, or electronic equivalent**.

[(A) Appendix A shall be used for reports due on or before April 1, 1990.

(B) Appendix B shall be used for reports due after April 1, 1990.]

(2) Mass-marketed policies *[shall be]* **are** considered to be individual policies.

AUTHORITY: sections 374.045, 374.190, and [376.870, RSMo 1986] 376.874[.2], RSMo [Supp. 1989] 2016. This rule was previously filed as 4 CSR 190-14.117. Original rule filed Feb. 4, 1987, effective July 1, 1987. Amended: Filed Sept. 14, 1989, effective Jan. 1, 1990. Amended: Filed May 13, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is*

scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 600—Statistical Reporting
Chapter 3—Reporting Data on Residential and Auto Insurances

PROPOSED AMENDMENT

20 CSR 600-3.100 *[Required]* **Format** ***to be Used*** **in Reporting Data on Residential Insurance Coverages and Private Passenger Automobile Insurance**. The director is amending the rule title, the purpose statement, and sections (1), (2), (3), (4), and (6), deleting section (5), subsections (3)(A), (3)(B), and (3)(C), renumbering as necessary, and deleting the reporting instructions and transmittal form which follow the rule as appendices A and B in the *Code of State Regulations*.

PURPOSE: This proposed amendment clarifies and modernizes the rule by updating statutory references, simplifying filing procedures, and utilizing modern technology. The proposed amendment also clarifies whether the data submitted are open or closed records.

PURPOSE: This rule states the format [in which] ***to be used by*** *an insurer [is required to file]* ***when filing*** *with the Department of Insurance its report of all premium and loss data in accordance with sections 374.405 and 374.455, RSMo.*

(1) *[Each]* **To comply with sections 374.405 and 374.455, RSMo,** insurers *[annually,]* **shall file with the Department of Insurance** on or before March 1 of each year *[, shall file electronically by three and one-half inch (3 1/2") diskette, tape, cartridge or a combination thereof, with the Department of Insurance its]* data **in an electronic format** for the previous calendar year regarding premium and losses under those policy types defined pursuant to section 374.400, RSMo as homeowners' insurance, dwelling owners' insurance, renters' or tenants' insurance**,** or residential fire insurance and defined pursuant to section *[374.455]* **374.450**, RSMo as private automobile insurance. Insurance products known as farmowners insurance and mobile home insurance are also included within these defined policy types.

(2) The data *[shall be that data]* **is to** pertain*[ing]* to the basic primary coverage without inclusion of data regarding any endorsement attached to an insurance policy, unless otherwise specified in the reporting instructions *[which are attached to this rule as Appendix A]* **set forth on the department's website**.

(3) The *[format in which the data is to be filed is as follows:]* **reporting instructions set forth on the department's website are to be followed.**

[(A) The data shall be reported by five (5)- digit zip code for the principal garaging location or the location of the property insured;

(B) The reporting instructions as stated in Appendix A of this rule shall be followed; and

(C) The Transmittal Form as shown in Appendix B of this rule shall be attached with each filing made pursuant to this rule.]

(4) If an insurer *[or group of insurers, or both,]* has less than five hundred (500) annual exposures in this state during the calendar year, then that insurer *[or group of insurers or both,]* need not report data as *[required]* **set forth** by this rule; provided, however that the insurer *[shall]* maintain accurate data in the format *[required]* **provided** by this rule and make that data available to the department upon request.

[(5) If an insurer fails to timely file the data in the format as required by this rule, the insurer shall be subject to penalty including, but not limited to, those penalties provided in section 374.215.1, RSMo. If an insurer files data required by this rule which is materially false, the insurer shall be subject to penalty including, but not limited to those penalties provided in sections 374.210 and 374.215.2, RSMo.]

*[(6)]***(5)** *[The data reported pursuant to this rule and sections 374.405 and 374.455, RSMo shall be deemed records which are open to the inspection of the public in accordance with sections 374.070 and 610.011, RSMo. Any insurance company claiming that this data constitutes a trade secret or proprietary information shall comply with the procedures as set forth in 20 CSR 10-2.400(3)(L).]* **Each reporting insurer's data are deemed trade secrets and closed records. However, data in aggregate form are deemed open records available for public inspection.**

AUTHORITY: sections 374.045, 374.405, and 374.455, RSMo 2016. Original rule filed Aug. 17, 1993, effective May 9, 1994. Emergency amendment filed April 6, 1995, effective April 16, 1995, expired Aug. 13, 1995. Amended: Filed April 14, 1995, effective Nov. 30, 1995. Amended: Filed Aug. 28, 1997, effective April 30, 1998. Amended: Filed May 13, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Stewart Freilich, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 9:00 am, July 18, 2019, at 301 W. High Street, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 700—Insurance Licensing
Chapter 1—Insurance Producers

PROPOSED AMENDMENT

20 CSR 700-1.170 Licensing Procedures and Standards for Limited Lines Self-Service Storage Insurance Producers. The director is amending sections (1)–(4).

PURPOSE: This amendment streamlines the existing rule and adds provisions regarding license renewals. The director is amending sections (1) through (4).

(1) *[Application and Fees. Application]* **Applicants** for a limited lines self-service storage insurance producer license shall *[include the following:]* **submit to the department a**

[(A) A] completed application form, included herein as Exhibit 1 of this rule, *[or any form that substantially comports with the specified form;]* and

(B) One] **a one** hundred dollar ($100) application fee.

(2) *[Qualified Training Program.*

(A)] Applicants for a limited lines self-service storage insurance producer license shall complete a training course approved by the director **pursuant to section 379.1640.2(1)(d)d, RSMo,** as listed on the department's limited lines self-service storage insurance producer webpage at www.insurance.mo.gov, **except that**

[(B) A] **any** individual licensed in Missouri as an insurance producer with the property **& casualty** insurance line of authority *[shall be]* **is** deemed *[as]* **to** hav*[ing]***e** completed *[the]* **a** qualified training program *[requirement described in subsection (2)(A)]*.

(3) *[Register of Individuals Offering Self-Service Storage Insurance on Limited Lines Self-Service Storage Insurance Producer's Behalf.*

(A) Contents of register to be established, maintained, and updated by the limited lines self-service storage insurance producer.

1. Each limited lines self-service storage insurance producer shall establish at the time of licensure, and thereafter maintain and update annually a self-service storage register in] **Pursuant to section 379.1640.2(b), RSMo, the director specifies** the form included herein as Exhibit 2*[, or in a substantially similar document that shall include the following:]* **of this rule**

[A. Name, address, telephone number, and email address of the limited lines self-service storage insurance producer;

B. Name, address, telephone number, and email address of any officer or person who directs or controls the limited lines self-service storage insurance producer's operations;

C. Name, address, telephone number, and email address of] **for the purpose of identifying** each individual that offers self-service storage insurance on behalf of the limited lines self-service storage insurance producer*[;]***.**

[D. The self-service storage facility's federal tax identification number; and

E. Dated signature by the limited lines self-service storage insurance producer, under penalty of perjury, certifying that each individual listed on the self-service storage register complies with 18 U.S.C. Section 1033.

(B) The limited lines self-service storage insurance producer shall submit the self-service storage register within thirty (30) days upon request by the department.]

(4) *[The limited lines self-service storage insurance producer shall require each employee and authorized representative of the self-service storage insurance producer to receive a program of instruction or training that has been reviewed and approved by the director. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.]* **Applicants for renewal of their limited lines self-service storage insurance producer license shall submit to the department a completed application form, included herein as Exhibit 3 of this rule, and a one hundred dollar ($100) application fee.**

AUTHORITY: sections 374.045 and 379.1640, RSMo 2016. Emergency rule filed Aug. 18, 2016, effective Aug. 28, 2016, expired Feb. 23, 2017. Original rule filed Aug. 18, 2016, effective March 30, 2017. Amended: filed May 13, 2019.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for July 18, 2019 at 9 a.m. at 301 W. High, Room 530, Jefferson City, Missouri 65101.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.016 Pharmacy Operating Procedures During Declared Disasters. The board is amending section (2).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to clarify disaster procedures for Missouri pharmacies.

(2) In cases where a disaster as defined in section (1) has been declared, any pharmacy located within the disaster area may arrange to move to a temporary location to better serve the public or provide pharmacy services from a mobile unit that is under the control and management of the pharmacist-in-charge.

(A) *[The following constitutes requirements for maintaining temporary or mobile facilities]* **Temporary or mobile facilities must comply with the following**:

1. Temporary or mobile pharmacy facilities shall only be located within the disaster area or adjacent county;

2. Temporary facilities may be maintained by a pharmacy operation for a period of up to six (6) months without applying for a change of location. *[Any pharmacy wishing]* **A change of location application is required if the pharmacy wishes** to maintain a temporary site for more than six (6) months or desires to remain permanently at the temporary site*[, must apply for a change of location as outlined in 4 CSR 220-2.020(4)]*;

3. Mobile pharmacy operations must cease services once the immediate disaster is over;

4. Temporary or mobile pharmacy facilities must inform the board of their location and provide an estimate of the time period for which the temporary or mobile pharmacy operation will be needed; and

5. The executive director *[shall have the authority to]* **may** approve or disapprove temporary or mobile pharmacy facilities and shall make arrangements for appropriate monitoring and inspection of the pharmacy on a case-by-case basis.

A. Approval of this type of operation will be based on the need, type**,** and scope of disaster, as well as the ability of the pharmacy to comply with state and federal drug laws in addition to section 338.240, RSMo.

B. Temporary or mobile pharmacy facilities shall cease operations *[under the provisions of this rule]* if any previous approval is withdrawn.

C. Any decision made concerning the approval of a temporary or mobile pharmacy *[shall]* **does** not interfere with any rights or

privileges of a pharmacy permit holder at the original location of operation or prevent a permit holder from applying for a change of location as outlined in *[4 CSR 220-2.020(4)]* **the board's rules**.

*AUTHORITY: sections 338.210 and 338.280, RSMo [1994] **2016**. This rule originally filed as 4 CSR 220-2.016. Original rule filed May 4, 1995, effective Dec. 30, 1995. Moved to 20 CSR 2220-2.016, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.050 Public Complaint Handling and Disposition Procedure. The board is amending sections (1)–(7).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to clarify the board's complaint handling procedures.

(1) *[The State Board of Pharmacy shall receive and process each complaint made against any licensee or registrant or other person or entity, which complaint alleges certain acts or practices which may constitute one (1) or more violations of the provisions of Chapter 338, RSMo.]* Any member of the public, the profession or any federal, state**,** or local official may make and file a complaint with the board. *[Complaints shall be received from sources outside Missouri and will be processed in the same manner as those originating within Missouri.]* No member of the State Board of Pharmacy shall file a complaint with this board while s/he holds that office, unless that member excuses him/herself from further board deliberations or activity concerning the matters alleged within that complaint. Any staff member or employee of the board may file a complaint pursuant to this rule in the same manner as any member of the public.

(2) Complaints should be mailed or delivered to the following address: State Board of Pharmacy, 3605 Missouri Blvd., PO Box 625, Jefferson City, MO 65102. *[However, actual receipt of the complaint by the board at its administrative offices in any manner shall be sufficient.]* Complaints may be based upon personal knowledge or upon information and belief*[, reciting information received from other sources]*.

(3) **Except as otherwise authorized by the board or executive director,** *[A]***all** complaints shall be made in writing and *[shall fully]* identify their maker by name and address. Complaints may be made on forms provided by the board, which *[shall be]* **are** available upon request. Complaints need not be made by affidavit, but oral or telephone communications will not be considered or processed as complaints **unless otherwise authorized by the board or the executive director**. *[Any person attempting to make an oral or telephone complaint against an individual will be provided with a complaint form and requested to complete it and return it to the board.]* Any staff member or employee of the board may make and file a complaint based upon information and belief, in reliance upon oral, telephone**,** or written but unsigned communications received by the board, unless those communications are believed by that staff member or employee to be false.

(4) Each complaint received under this rule shall be recorded by the board*[. Complaints shall be logged]* in consecutive order as received. The record shall contain each complainant's name and address; the name and address of the subject(s) of the complaint; the date each complaint is received by the board; a brief statement of the acts complained of, and the ultimate disposition of the complaint. This record shall be a closed record of the board.

(5) The complainant shall be informed in writing as to whether the complaint has been dismissed by the board or is being referred to legal counsel for legal action. The complainant may be notified of the ultimate disposition of the complaint, excluding judicial appeals and may be provided with a copy of the decisions (if any) of the Administrative Hearing Commission and the board. The provisions of this section *[shall]* **do** not apply to complaints filed by staff members or employees of the board, based upon information and belief, acting in reliance on third-party information received by the board.

(6) Both the complaint and any information obtained as a result of the complaint investigation *[shall be considered]* **are** a closed record of the board and shall not be available for inspection by the public.

(7) This rule *[shall not be deemed to]* **does not** limit the board's authority to file a complaint with the Administrative Hearing Commission or with a court, charging a licensee, permittee**,** or other person or entity with any actionable conduct or violation, whether or not this complaint exceeds the scope of the acts charged in a preliminary public complaint filed with the board and whether or not any public complaint has been filed with the board.

*AUTHORITY: sections 338.140 and 338.280, [RSMo 2000 and 620.010.15(6),] RSMo [Supp. 2004] **2016**. This rule originally filed as 4 CSR 220-2.050. Original rule filed Jan. 11, 1982, effective June 1, 1982. Amended: Filed Aug. 27, 1985, effective Nov. 11, 1985. Amended: Filed Aug. 29, 1986, effective Dec. 25, 1986. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.060 Gold Certificates. The board is amending section (1) and deleting section (2).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to clarify the board's procedures for issuing gold certificates.

(1) The Missouri Board of Pharmacy shall issue gold certificates to all pharmacist licensees who have been regularly licensed as pharmacists in Missouri for fifty (50) years *[These gold certificates shall be distinctive in coloration and text from other documentary licenses issued by the board and shall be designed to appropriately recognize each recipient pharmacist for his/her half century of professional practice]* **without charge to the recipient**. Gold certificates are honorific in nature and confer no right to practice pharmacy upon the recipient.

[(2) The awarding of gold certificates shall be made by the Missouri Board of Pharmacy routinely and without charge to the recipient.]

*AUTHORITY: section 338.140, RSMo [Supp. 1989] **2016**. This rule originally filed as 4 CSR 220-2.060. Original rule filed March 14, 1983, effective June 11, 1983. Moved to 20 CSR 2220-2.060, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.080 Electronic Prescription Records. The Board is amending sections (2), (4), (8), (12), and (13) of this rule.

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to modernize rule language governing electronic prescription records.

(2) EDP systems shall comply with the requirements of section 338.100, RSMo, and *[shall be]* capable of storing and retrieving the following information concerning the original filling or refilling of any prescription:

(Q) Any other change or alteration made in the original prescription based on contact with the prescriber to show a clear audit trail*[. This shall include]* **including**, but *[is]* not limited to, a change in quantity, directions, number of refills, or authority to substitute a drug.

(4) Except as otherwise provided by 20 CSR 2220-2.083, prescription hard copies must be maintained and filed by either the sequential prescription label number or by a unique readily retrievable identifier. For verbal, telephone, or electronic *[data transmission]* prescriptions, a hard copy representation of the prescription shall be made and filed which contains all of the information in section (2). Prescription hard copies must be retrievable at the time of inspection, except as otherwise provided by 20 CSR 2220-2.010(1)(J). For purposes of this subsection an "electronic *[data transmission]* prescription" *[shall be]* **is** defined as provided in 20 CSR 2220-2.085.

(8) An auxiliary record-keeping system shall be established for the documentation of refills if the EDP system is inoperative for any reason. The auxiliary system shall ensure that all refills are authorized by the original prescription or prescriber. When this EDP system is restored to operation, the information regarding prescriptions filled and refilled during the inoperative period shall be entered into the EDP system within seven (7) working days. However, nothing in this section *[shall preclude]* **precludes** the pharmacist from using his/her professional judgment for the benefit of a patient's health and safety.

(12) The EDP system shall be able to provide a listing of drug utilization **by date** for any drug for a minimum of the preceding twenty-four- (24-) month period*[. Drug utilization information shall be available by date(s),]* **that includes the** specific drug product, patient name, or practitioner. If requested to do so, the pharmacy shall have three (3) working days to provide the report.

(13) The provisions of this rule *[shall not conflict with]* **do not preempt** any federal laws or regulations. If any part of this rule is declared invalid by a court of law, that declaration shall not affect the other parts of the rule.

*AUTHORITY: sections 338.100 and 338.140, [RSMo Supp. 2012, and section] 338.280, RSMo [2000] **2016**. This rule originally filed as 4 CSR 220-2.080. Original rule filed March 8, 1984, effective Aug. 11, 1984. Amended: Filed Nov. 4, 1985, effective Feb. 24, 1986. Rescinded and readopted: Filed Dec. 5, 1988, effective March 11, 1989. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.150 Mandatory Reporting Rule. The board is deleting sections (1), (4), and (5), amending sections (2) and (3), and renumbering as necessary.

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language.

[(1) The board of pharmacy shall receive and process any report from a hospital or ambulatory surgical center concerning any disciplining action against a licensed pharmacist or the voluntary resignation of any licensed pharmacist against whom any complaints or reports have been made which might have led to final disciplinary action.]

*[(2)]***(1)** Reports to the board **from a hospital or ambulatory surgical center concerning any disciplinary action against a licensed pharmacist or the voluntary resignation of any licensed pharmacist against whom any complaints or reports have been made which might have led to final disciplinary action** shall comply with *[the minimum requirements as set forth in]* section 383.133, RSMo and this rule*[. This information shall include, but not be limited to]* **and include at a minimum**:

(A) The name, address and telephone number of the person making the report;

(B) The name, address and telephone number of the person who is the subject of the report;

(C) A brief description of the facts which gave rise to the issuance of the report, including the dates of occurrence deemed to necessitate the filing of the report;

(D) If court action is involved and known to the reporting agent, the identity of the court, including the date of filing and the docket number of the action;

(E) A statement as to what final action was taken by the institution; and

(F) That the report is being submitted in order to comply with the reporting provisions of Chapter 383, RSMo.

*[(3)]***(2)** *[The director of pharmacy or pharmacist-in-charge shall report any actions as described in section (1) to the chief executive officer (CEO) or his/her designee.]* Any activity that is construed to be a cause for disciplinary action according to section 338.055, RSMo or results in potential or actual harm to the public shall be deemed reportable to the board. *[Nothing in this rule shall be construed as limiting or prohibiting]* **This rule does not limit or prohibit** any pharmacist from reporting a violation of the Pharmacy Practice Act directly to the Missouri Board of Pharmacy.

[(4) In response to an inquiry from a hospital or ambulatory surgical center regarding reports received by the board on a specific pharmacist, the board shall provide the following information:

(A) Whether any reports have been received;

(B) The nature of each report; and

(C) The action which the board took on each report or if the board has taken action on the report.

(5) Each report received shall be acknowledged in writing. The acknowledgment shall state that the report is being reviewed by the board or is being investigated and shall be referred to the board or an appropriate board subcommittee for consideration. The institution subsequently shall be informed in writing as to whether the report has been dismissed by the board or is being referred to legal counsel for filing with the Administrative Hearing Commission or for other legal action. The institution may be notified of the ultimate disposition of the report excluding judicial appeals and may be provided with a copy of the decisions (if any) of the Administrative Hearing Commission and the board.]

*[(6)]***(3)** The provisions of this rule are declared severable. If any portion of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction.

*AUTHORITY: sections 338.140[, RSMo Supp. 1989] and 383.133, RSMo [1986] **2016**. This rule originally filed as 4 CSR 220-2.150. Original rule filed Aug. 4, 1987, effective Jan. 29, 1988. Moved to 20 CSR 2220-2.150, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.180 Public Records. The board is amending sections (1) and (3) and deleting sections (4)-(6).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to correct a rule citation.

(1) All public records of the State Board of Pharmacy *[shall]* **will** be open for inspection and copying by any member of the general public during normal business hours, holidays excepted, except for those records closed pursuant to section 610.021, RSMo. All public meetings of the Board of Pharmacy not closed pursuant to the provisions of section 610.021, RSMo will be open to any member of the public.

(3) When a request for inspection of public records is made and the individual inspecting the records requests copies of the records, the board will collect the appropriate fee for costs for inspecting and copying of the records, as outlined in the board's fee rule, *[4 CSR 220-4.020]* **20 CSR 2220-4.100**. The board may require payment of the fees prior to making available any public records.

[(4) When a request for access to public records is made and the custodian believes that access is not required under the

provisions of Chapter 610, RSMo, the custodian shall inform the individual or entity making the request that compliance with the request cannot be made, specifying in particular what sections of Chapter 610, RSMo require that the record remain closed. Any such correspondence or documentation of the denial made for access to records shall be copied to the Board of Pharmacy general counsel. Whenever the custodian denies access to the records, the custodian also shall inform the individual requesting the records that s/he may appeal directly to the Board of Pharmacy for access to the records requested. The appeal and all information pertaining to the appeal shall be placed on the meeting agenda of the Board of Pharmacy for its next regularly scheduled meeting. In the event that the board decides to reverse the decision of the custodian, the board shall direct the custodian to so advise the person requesting access to the information and supply the access to the information during regular business hours at the convenience of the requesting party.

(5) The custodian shall maintain a file which will contain copies of all written requests for access to records and responses to the requests. These requests shall be maintained on file with the board for a period of one (1) year and will be maintained as a public record of the board open for inspection by any member of the general public during regular business hours.

(6) Pursuant to section 620.111, RSMo any complaints, investigation reports and accompanying documents or exhibits that are considered closed documents under Chapter 610 or 620, RSMo, and are possessed by the board or any of its agents shall not be disclosed to any member of the public or to a licensee until the investigation is completed.

(A) Federal or state agency documents shall not be released without the written consent of the federal or state agency involved.]

*AUTHORITY: sections 338.140[,] **and** 338.280, **RSMo 2016, and** Chapters 610 and 620, RSMo [1994] **2016, Supp. 2017, and Supp 2018**. This rule originally filed as 4 CSR 220-2.180. Original rule filed Jan. 19, 1988, effective April 28, 1988. Amended: Filed June 26, 1995, effective Feb. 25, 1996. Moved to 20 CSR 2220-2.180, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.300 Record Confidentiality and Disclosure. The board is amending sections (2) and (4).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to authorize disclosure of confidential records as allowed by state and federal law.

(2) Confidential records *[shall not be released to anyone except]* **may only be released to**—

(A) The patient;

(B) A health care provider involved in treatment activities of the patient;

(C) Lawful requests from a court or grand jury;

(D) A person authorized by a court order;

(E) Any other person or entity authorized by a patient to receive such information;

(F) For the transfer of medical or prescription information between pharmacists as provided by law;

(G) Government agencies acting within the scope of their statutory authority; or

(H) A person or entity to whom such information may be disclosed under 45 CFR Parts 160, 164 and 165 (the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996) **or other applicable state/federal law**.

(4) Methods to access, transmit, store, analyze, or purge confidential information shall be implemented using procedures generally recognized as secure by experts qualified by training and experience. Procedures shall be in place to ensure that purged confidential information cannot be misused or placed into active operation without appropriate authorization as provided in this rule. Internet connectivity or remote access tied directly to systems containing confidential information must be secure *[as provided for in 4 CSR 220-2.085(2)(B)]*.

*AUTHORITY: sections 338.100, 338.140 and 338.280, RSMo [2000] **2016**. This rule originally filed as 4 CSR 220-2.300. Original rule filed May 4, 1995, effective Dec. 30, 1995. Rescinded and readopted: Filed Nov. 1, 2000, effective June 30, 2001. Amended: Filed Dec. 15, 2003, effective July 30, 2004. Moved to 20 CSR 2220-2.300, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.600 Standards of Operation for a Class F: Renal Dialysis Pharmacy. The board is amending the purpose statement

and all sections of the rule.

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language.

PURPOSE: This rule [incorporates the provisions of SB 141 and] defines minimum standards for a Class F: Renal Dialysis Pharmacy.

(1) A Class F pharmacy (renal dialysis) shall be limited in scope to the provision of dialysis products and supplies to persons with chronic kidney failure for self-administration at the person's home or specified address. Pharmacy services and dialysis supplies and products provided by a Class F pharmacy shall be limited to the distribution and delivery of drugs and devices as provided within this rule. All drugs and devices must be ordered by an authorized prescriber for administration or delivery to a person with chronic kidney failure for self-administration at the person's home or specified address. All dialysis supplies and products provided by a Class F pharmacy shall be prepackaged and *[shall be]* covered by an approved New Drug Application (NDA) or 510(k) application issued by the Food and Drug Administration (FDA).

(2) A Class F pharmacy shall maintain a pharmacist-in-charge on a consultant basis who shall review pharmacy operations at least weekly. *[The pharmacist-in-charge of a Class F pharmacy will be responsible for the following requirements]* **Class F pharmacies shall ensure**:

(A) *[Ensure that the use]* **Use** of legend drugs and devices that are provided to a person for the treatment of chronic kidney disease for self-administration at the person's home or specified address *[shall be]* **are** under the professional supervision of an appropriate practitioner licensed under Missouri law.

(B) *[Ensure that o]***Only** drugs and devices that have been ordered by an authorized prescriber and are included on the list of approved formulary drugs and devices are provided to patients;

(C) *[Ensure that n]***No** drugs or devices *[shall be]* **are** dispensed to a patient until adequate training in the proper use and administration of such products has been completed;

(D) *[Ensure that p]***Proper** documentation of drug and device distributions and deliveries are maintained by the Class F pharmacy and are made available upon request to practitioners involved in the care of the patient and to board of pharmacy representatives;

(E) *[Maintain a]* **A** policy and procedure manual *[that shall be]* **is maintained that is** available for inspection by board of pharmacy personnel. The manual shall include a quality assurance program with which to monitor the qualifications, training and performance of personnel; and

(F) The pharmacist-in-charge *[shall be]* **is** responsible for the drug/device delivery system and *[shall establish]* **for establishing** a written protocol for the implementation of the delivery system including methods for supervising drug/device deliveries to patients of the pharmacy.

1. Any written protocols shall be available for inspection by board of pharmacy personnel.

2. Any changes to the policy and procedure manual or to written protocols must be approved by the pharmacist-in-charge.

[(3) Drug Formulary List/Device List. The pharmacy shall submit a list of drugs and/or devices which must be approved by the board of pharmacy.]

*[(4)]***(3)** A Class F pharmacy *[shall]* **may** deliver products to a person with chronic kidney failure only upon the receipt of a valid prescription from an authorized prescriber specifying or including:

(A) Documents that the intended recipient will require such products for the appropriate treatment of the disease and that the intended recipient has been trained in home dialysis therapy;

(B) The duration of the prescriber's order, not to exceed one (1) year, including all authorized refills; and

(C) The name and product code of each product prescribed and the quantity prescribed.

*[(5)]***(4)** Personnel of the pharmacy shall assemble the products to be delivered pursuant to the prescriber's order(s). In assembling such products for delivery, the pharmacy shall take steps necessary to assure the following:

(A) The code numbers and quantities of the products assembled match the code numbers identified in the prescriber's order(s);

(B) Any products bearing an expiration date have a minimum of three (3) full months of shelf-life remaining;

(C) A visual inspection **is completed** of all drugs and devices for compliance with the prescriber's order(s) and with all labeling requirements as set forth in 338.059, RSMo. Manufacturer sealed case lots shall be labeled with the name of the patient, date, and a control number that serves as a unique patient identifier number; and

(D) Products ordered by a prescriber and provided to patients of the pharmacy shall be delivered either by personnel of the pharmacy or by a carrier authorized by the pharmacy.

1. Upon the delivery to patients of any drugs/devices, pharmacy personnel or the approved carrier shall confirm receipt by the patient or the patient's designee and that the number of units delivered equals the number of units identified by documentation supplied by the pharmacy.

*[(6)]***(5)** Class F pharmacies shall *[comply with all of the following]* **ensure**:

(A) The license of the pharmacy *[shall be]* **is** displayed in plain view at the pharmacy location;

(B) The pharmacy *[shall be]* **is** open such hours as are necessary to safely and effectively dispense and deliver supplies to those persons designated by the applicable prescriber;

(C) The pharmacy *[must maintain]* **maintains** sufficient space and storage capabilities as necessary to carry out its operations; and

(D) All drugs and/or devices shall be properly identified and any outdated, misbranded or adulterated items shall be segregated from the active inventory within a clearly separate and defined area and *[shall be]* held separately until the item is destroyed or returned to a licensed drug distributor.

*AUTHORITY: sections 338.140 and 338.220, [RSMo Supp. 1997] and 338.280, RSMo [1994] **2016**. This rule originally filed as 4 CSR 220-2.600. Original rule filed Jan. 20, 1998, effective Aug. 30, 1998. Moved to 20 CSR 2220-2.600, effective Aug. 28, 2006. Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2220-2.800 Vacuum Tube Drug Delivery System. The board is amending section (2).

PURPOSE: This rule is being amended pursuant to Executive Order 17-03 to remove unnecessary/duplicative rule language and to correct a rule citation.

(2) *[All vacuum tube delivery systems installed after September 1, 1998, shall comply with the minimum standards set forth in this rule.]* Any vacuum tube delivery system already installed in a pharmacy prior to September 1, 1998, will not be required to comply with this rule; except that, should the vacuum tube delivery system or any part thereof require replacement, change, or upgrading after September 1, 1998, the system or any part of the system being replaced, changed or upgraded shall comply with the minimum standards set forth in this rule. This exemption does not relieve a pharmacy of its duty to maintain adequate security measures as required by *[4 CSR 220-2.010(1)(H)]* **Chapter 195, RSMo, 19 CSR 30-1, or the rules of the board**; nor does it relieve pharmacists from their duty to provide patient counseling as required by *[4 CSR 220-2.190]* **20 CSR 2220-2.190**.

AUTHORITY: sections 338.140[, RSMo Supp. 1997] and 338.280, RSMo [1994] ***2016***. This rule originally filed as 4 CSR 220-2.800. *Original rule filed Aug. 21, 1998, effective Feb. 28, 1999.* Moved to 20 CSR 2220-2.800, effective Aug. 28, 2006. *Amended: Filed May 13, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 6—Pharmaceutical Care Standards

PROPOSED RESCISSION

20 CSR 2220-6.030 Provision of Drug and/or Medical Information. This rule defined requirements for providing drug and/or medical information by pharmacists.

PURPOSE: This rule is being rescinded pursuant to Executive Order 17-03.

AUTHORITY: sections 338.095, RSMo Supp. 1993, 338.010, RSMo Supp. 1990, 338.140, RSMo Supp. 1989 and 338.280, RSMo 1986. This rule originally filed as 4 CSR 220-6.030. Original rule filed March 1, 1994, effective Sept. 30, 1994. Moved to 20 CSR 2220-6.030, effective Aug. 28, 2006. Rescinded: Filed May 13, 2019.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri State Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 7—Licensing

PROPOSED AMENDMENT

20 CSR 2220-7.080 Pharmacist License Renewal and Continuing Pharmacy Education. The board is amending section (12).

PURPOSE: This amendment eliminates the mandatory delinquent fee and incorporates a graduated delinquent fee schedule.

(12) The board may audit a licensee to assess the authenticity and validity of continuing education hours submitted for relicensure. Failure to provide proof of completion of the required continuing education credits when requested to do so by the board shall be considered a violation.

(A) In accordance with section 338.060, RSMo, any licensee that has not completed and retained the required evidence of all required continuing education shall **complete any outstanding continuing education and** pay *[any delinquent fees as prescribed by the board]* **a delinquent fee as provided by this rule** and may be subject to disciplinary action pursuant to section 338.055, RSMo. The board may also audit past renewal periods and/or require that proof of continuing education credits be submitted with the licensee's renewal application.

(B) The following continuing education delinquent fees are applicable:

1. Less than one (1) hour missing one hundred dollars ($100);

2. Two (2) to ten (10) hours missing five hundred dollars ($ 500);

3. Eleven (11) to fifteen (15) hours missing seven hundred fifty dollars ($750); or

4. Sixteen (16) or more hours missing one thousand dollars ($1,000).

AUTHORITY: sections 338.020, 338.060, [and] 338.070, [RSMo 2000,] and [section] 338.140, RSMo [Supp. 2012] ***2016****. Original rule filed Jan. 10, 2013, effective Aug. 30, 2013. Amended: Filed May 6, 2019.*

PUBLIC COST: This proposed amendment will result in a decrease of approximately thirty-nine thousand dollars ($39,000) biennially to

the Missouri Board of Pharmacy. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Pharmacy, PO Box 625, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 526-3464, or via email at pharmacy@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this rule in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Insurance, Financial Institutions and Professional Registration
Division Title: State Board of Pharmacy
Chapter Title: Licensing

Rule Number and Name:	20 CSR 2220-7.080 Pharmacist License Renewal and Continuing Pharmacy Education
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Fiscal Impact
State Board of Pharmacy	$ 39,000 *(Biennial Revenue Decrease)*

III. WORKSHEET

Estimated # of Applicants/Licensees	Affected Agency	Description of Costs	Calculation of Estimates	TOTAL REVENUE DECREASE
52	Board of Pharmacy	Pharmacist Continuing Education Delinquent Fee	$ 1,000 delinquent continuing education fee x 52 delinquent pharmacists biennially decreased by 75%	$ 39,000 biennially
TOTAL ESTIMATED COSTS				$ 39,000 *(Projected biennial revenue decrease)*

IV. ASSUMPTIONS

1. Missouri pharmacists renew biennially in even-numbered years.
2. The Board estimates approximately fifty-two (52) pharmacists will be required to remit the delinquent continuing education fee each renewal period based on an average of delinquent continuing education fees received in FY15, FY17, and FY19 to date. Of the fifty-two (52) estimated pharmacists, the Board estimates a 75% reduction in the amount of fees owed based on the proposed graduated fee scale and Board historical data on the number of hours typically deficient (52 pharmacists x $ 1,000 decreased by 75% = $39,000) .
3. Actual revenue decreases may vary based on the number of pharmacists who fail to complete the required continued education requirements.
4. The projected revenue decrease will result in a net savings to Missouri pharmacists.
5. The total revenue decrease is estimated to recur biennially for the life of the rule.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2230—State Board of Podiatric Medicine
Chapter 1—Organization and Description of Board

PROPOSED AMENDMENT

20 CSR 2230-1.010 General Organization. The board is amending sections (6) and (8).

PURPOSE: This rule is being amended to update information relating to the board.

(6) The board *[shall]* **will** have at least one (1) regularly scheduled annual meeting and such other meetings as determined by the board. *[The time and location for each meeting may be obtained by contacting the board office at PO Box 423, Jefferson City, MO 65102-0423 or by visiting the board's website at http://pr.mo.gov/podiatrists.asp.]*

(8) Members of the public may obtain information from the board or make submissions to the board, by writing the board office at PO Box *[423]* **1335**, Jefferson City, MO 65102-*[0423]***1335, by calling (573) 751-0873, sending a fax to (573) 751-6301, sending an email to podiatry@pr.mo.gov,** or by visiting the board's website at http://pr.mo.gov/podiatrists.asp.

*AUTHORITY: section[s] 330.140, RSMo [2000 and 536.023.3, RSMo Supp. 2006] **2016**. This rule originally filed as 4 CSR 230-1.010. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. Rescinded and readopted: Filed Dec. 9, 1981, effective March 11, 1982. Amended: Filed Oct. 30, 1997, effective April 30, 1998. For intervening history, please consult the **Code of State Regulations**. Amended: Filed May 6, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Podiatric Medicine, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-751-6301, or via email at podiatry@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety- (90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 1—OFFICE OF ADMINISTRATION
Division 30—Division of Facilities Management, Design and Construction
Chapter 3—Capital Improvement and Maintenance Program

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section(s) 8.250, 8.255, 8.310, and 8.320, RSMo 2016, the Director of the Office of Administration, Division of Facilities Management, Design and Construction amends a rule as follows:

1 CSR 30-3.025 Procurement of Construction and Management Services **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2019 (44 MoReg 38-45). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 30—Division of Facilities Management, Design and Construction
Chapter 3—Capital Improvement and Maintenance Program

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section 8.320, RSMo 2016, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 30-3.060 Determination of Contractor Responsibility **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 45). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 30—Division of Facilities Management, Design and Construction
Chapter 4—Facility Maintenance and Operation

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under sections 8.320 and 8.360, RSMo 2016, the Director of the Office of Administration, Division of Facilities Management, Design and Construction amends a rule as follows:

1 CSR 30-4.020 Facility Management **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2019 (44 MoReg 45-49). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 30—Division of Facilities Management, Design and Construction
Chapter 4—Facility Maintenance and Operation

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under sections 8.320 and 8.360, RSMo 2016, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 30-4.030 Maintenance Program Standards and Procedures **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 49). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 30—Division of Facilities Management, Design and Construction
Chapter 4—Facility Maintenance and Operation

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under sections 8.320 and 8.360, RSMo 2016, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 30-4.040 Facility Safety and Security **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 49-50). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 35—Division of Facilities Management
Chapter 2—Leasing

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section 34.030, RSMo Supp. 2017, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 35-2.010 Rule Objectives **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 50). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 35—Division of Facilities Management
Chapter 2—Leasing

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section 34.030, RSMo Supp. 2017, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 35-2.020 Definitions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 50). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 35—Division of Facilities Management
Chapter 2—Leasing

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under sections 8.110 and 8.320, RSMo 2016, and sections 34.030 and 37.005, RSMo Supp. 2017, the Director of the Office of Administration, Division of Facilities Management, Design and Construction amends a rule as follows:

1 CSR 35-2.030 Procurement and Management of Leased Real Property **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2019 (44 MoReg 50-52). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 35—Division of Facilities Management
Chapter 2—Leasing

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section 34.030, RSMo Supp. 2017, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 35-2.040 Lease Acquisition **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 52). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 1—OFFICE OF ADMINISTRATION
Division 35—Division of Facilities Management
Chapter 2—Leasing

ORDER OF RULEMAKING

By the authority vested in the Director of the Office of Administration, Division of Facilities Management, Design and Construction under section 34.030, RSMo Supp. 2017, the Director of the Office of Administration, Division of Facilities Management, Design and Construction rescinds a rule as follows:

1 CSR 35-2.050 Management of Leased Real Property **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2019 (44 MoReg 52). No changes have been made in the proposed rescission,

so it is not reprinted here. This proposed rescission becomes effective in thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 9—Wildlife Code: Confined Wildlife: Privileges, Permits, Standards

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-9.110 General Prohibition; Applications **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2019 (44 MoReg 1022-1023). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 10—Wildlife Code: Commercial Permits: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-10.743 Commercial Establishments **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2019 (44 MoReg 1023). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-11.115 Closings **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2019 (44 MoReg 1023-1024). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 40—Gas Utilities and Gas Safety Standards

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under sections 386.250, 386.310, and 393.140, RSMo 2016, the commission adopts a rule as follows:

4 CSR 240-40.033 Safety Standards—Liquefied Natural Gas Facilities **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 1, 2019 (44 MoReg 500-501). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended March 4, 2019, and the commission held a public hearing on the proposed rule on March 5, 2019. The commission received timely written comments from the staff of the commission. Dean Cooper, representing Summit Natural Gas of Missouri, Darrin Chism, on behalf of Summit Natural Gas of Missouri, and Robert S. Berlin, representing the commission's staff, appeared at the hearing and offered comments.

COMMENT #1: Staff's written comment explains that the new rule to establish safety standards for liquefied natural gas facilities used in the transportation of gas by pipeline is necessary because such a facility has recently been opened in Missouri.
RESPONSE: The commission will make no change in response to this comment.

COMMENT #2: Darrin Chism, speaking on behalf of Summit Natural Gas of Missouri, the owner of the new liquefied natural gas facility that will be affected by this rule, explained that Summit fully supports the adoption of the rule.
RESPONSE: The commission will make no change in response to this comment.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 300—Office of Special Education

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092 and 162.685, RSMo 2016, the board hereby amends a rule as follows:

5 CSR 20-300.110 is amended.

A notice of proposed rulemaking was not published because state program plans required under federal education acts or regulations

are specifically exempt under section 536.021, RSMo. During December 2018 and January 2019, the Office of Special Education conducted two (2) public hearing webinars regarding proposed changes to the Part B State Plan implementing the Individuals with Disabilities Education Act (IDEA).

This rule becomes effective thirty (30) days after publication in the *Code of State Regulations*. This rule describes Missouri's services for children with disabilities, in accordance with Part B of the Individuals with Disabilities Education Act (IDEA).

5 CSR 20-300.110 Individuals with Disabilities Education Act, Part B. This order of rulemaking amends section (2) and amends the incorporated by reference material, *Regulations Implementing Part B of the Individuals with Disabilities Education Act*, to bring the program plan in compliance with federal statutes.

(2) The content of this state plan for the Individuals with Disabilities Education Act (IDEA), Part B, which is hereby incorporated by reference and made a part of this rule, meets the federal statute and Missouri's compliance in the following areas. A copy of the IDEA, Part B (revised February 2019) is published by and can be obtained from the Department of Elementary and Secondary Education, Office of Special Education, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480. This rule does not incorporate any subsequent amendments or additions.

AUTHORITY: sections 161.092 and 162.685, RSMo 2016. This rule previously filed as 5 CSR 70-742.140. Original rule filed April 11, 1975, effective April 21, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 10, 2019, effective July 30, 2019.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.250, RSMo 2016, the commissioner amends a rule as follows:

6 CSR 10-2.080 Higher Education Academic Scholarship Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 774-775). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.260, RSMo Supp. 2018, the commissioner amends a rule as follows:

6 CSR 10-2.100 Public Safety Officer or Employee's Child Survivor Grant Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 775). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.262, RSMo 2016, the commissioner amends a rule as follows:

6 CSR 10-2.120 Competitiveness Scholarship Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 775). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under sections 173.236, 173.250, 173.254, 173.262, and 173.1103, RSMo 2016, and sections 173.234 and 173.260, RSMo Supp. 2018, the commissioner amends a rule as follows:

6 CSR 10-2.140 Institutional Eligibility for Student Participation **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 776). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education

under section 173.1103, RSMo 2016, the commissioner amends a rule as follows:

6 CSR 10-2.150 Access Missouri Financial Assistance Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 776-777). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.234, RSMo Supp. 2018, the commissioner amends a rule as follows:

6 CSR 10-2.160 War Veteran's Survivors Grant Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 777). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.254, RSMo 2016, the commissioner amends a rule as follows:

6 CSR 10-2.170 Kids' Chance Scholarship Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 777). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 173.240, RSMo 2016, the commissioner amends a rule as follows:

6 CSR 10-2.180 Minority and Underrepresented Environmental Literacy Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 777-778). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 2—Student Financial Assistance Programs

ORDER OF RULEMAKING

By the authority vested in the Commissioner of Higher Education under section 160.545, RSMo Supp. 2018 and Executive Order 10-16, dated January 29, 2010, the commissioner amends a rule as follows:

6 CSR 10-2.190 A+ Scholarship Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 778-779). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 7—MISSOURI DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 4—Uniform Relocation Assistance

ORDER OF RULEMAKING

By the authority vested in the Missouri Highways and Transportation Commission under sections 226.150, 227.120, and 523.210, RSMo 2016, 42 USC Chapter 61, 23 CFR Part 710, and 49 CFR Part 24, the commission amends a rule as follows:

7 CSR 10-4.020 Relocation Assistance Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2019 (44 MoReg 274). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 50—Missouri State Highway Patrol
Chapter 2—Motor Vehicle Inspection Division

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State

Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.010 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 681-682). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 50—Missouri State Highway Patrol
Chapter 2—Motor Vehicle Inspection Division

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.030 Inspection Station Classification **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 682). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 50—Missouri State Highway Patrol
Chapter 2—Motor Vehicle Inspection Division

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.100 Requisition of Inspection Stickers, Authorities, and Decals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 682-683). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 50—Missouri State Highway Patrol
Chapter 2—Motor Vehicle Inspection Division

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent amends a rule as follows:

11 CSR 50-2.110 Issuance of Inspection Stickers and Decals **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 683). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 50—Missouri State Highway Patrol
Chapter 2—Motor Vehicle Inspection Division

ORDER OF RULEMAKING

By the authority vested in the superintendent of the Missouri State Highway Patrol under section 307.360, RSMo 2016, the superintendent adopts a rule as follows:

11 CSR 50-2.335 Autocycle Inspection **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 15, 2019 (44 MoReg 683-684). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division, under sections 208.153, 208.201, and 660.017, RSMo 2016, the division adopts a rule as follows:

13 CSR 70-3.280 Home and Community-Based Services Waiver Definitions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 1, 2019 (44 MoReg 563-564). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division, under sections 208.153, 208.201, and 660.017, RSMo 2016, the division adopts a rule as follows:

13 CSR 70-3.290 Home and Community-Based Services Waiver Setting Requirements **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 1, 2019 (44 MoReg 564-565). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division, under sections 208.153, 208.201, and 660.017, RSMo 2016, section 208.152, RSMo Supp. 2018, the division amends a rule as follows:

13 CSR 70-15.160 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 685-686). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Social Services, MO HealthNet Division (MHD) received two (2) comments on the proposed amendment.

COMMENT #1: Nanci Nikodym, Assistant Deputy Director, MO HealthNet Division stated that the effective date for changes to the outpatient drug reimbursement outlined in paragraph (1)(C)5. needs to be changed to April 1, 2019.
RESPONSE AND EXPLANATION OF CHANGE: The MO HealthNet Division has amended this final rule to reflect this change.

COMMENT #2: Daniel Landon, Senior Vice President of Governmental Relations, Missouri Hospital Association commented that in paragraph (1)(C)3. of 13 CSR 70-15.160, the deletion of the phrase ", included herein," confuses what MHA understands to be MHD's purpose for proposing the rule. The list of outpatient surgical procedures to which the fee schedule that is being incorporated by reference applies is presently codified at 13 CSR 70-15.160. MHA supports MHD's practice of explicitly listing the procedure codes to which fee schedule reimbursement will be applied. Because the list of codes will appropriately remain a part of the regulation, MHA recommends retaining the phrase ", included herein," in 13 CSR 70-15.160(1)(C)3 as clear reference to the cited November 30, 2018, procedure code listing.
RESPONSE: This amendment properly incorporates the Medicaid fee schedule into this regulation. The Outpatient Surgery Fee Schedule includes the listing of the procedure codes that this regulation incorporates. If the procedure codes or the fees change in the future, MHD will amend the regulation as necessary, which will be subject to public comment under section 536.026, RSMo.

13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology

(1) Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.

(C) Outpatient Hospital Services Reim-bursement Limited by Rule.

1. Certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

2. The technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule.

A. Effective for dates of service beginning October 1, 2011, through December 31, 2018, the technical component of outpatient radiology procedures, will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on one hundred twenty-five percent (125%) of the Medicare Physician fee schedule rate using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2016, 2017, and 2018 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at, https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule18.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

B. Effective for dates of service beginning January 1, 2019, the technical component of outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on ninety percent (90%) of the Medicare Physician fee schedule rate, effective January 1, 2018, using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2017, 2018, and 2019 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

3. Effective for dates of service beginning January 1, 2019, outpatient surgical procedures are reimbursed according to the outpatient Medicaid fee schedule. These rates are based on the 2018 Medicare Hospital Prospective Payment System Addendum B. The list of outpatient surgical procedure codes are reimbursed according to the Medicaid fee schedule. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf, November 30, 2018. This rule does not incorporate any subsequent amendments or additions.

4. Effective for dates of service beginning January 1, 2019 telehealth originating site fee is paid at the lesser of the billed amount or the outpatient fee schedule amount.

5. Effective for service dates beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

6. Services of hospital-based physicians and certified registered nurse anesthetists are reimbursed from a Medicaid fee schedule or the billed charge, if less.

7. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed by Medicare.

8. Reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services, except for public hospitals operated by the Department of Mental Health (DMH), shall be determined as follows:

A. Crossover claims for Medicare Part B outpatient hospital services in which Medicare was the primary payer and the MO HealthNet Division (MHD) is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Part B outpatient hospital services that were provided to MO HealthNet participants also having Medicare Part B coverage;

(II) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(III) The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment regardless of how the claim is submitted. Providers submitting crossover claims for Medicare Part B outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part B plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

B. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) outpatient hospital services in which a Medicare Advantage plan was the primary payer and MHD is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Advantage outpatient hospital services that were provided to MO. HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus);

(II) The crossover claim must be submitted as a Medicare UB-04 Part C Professional Crossover claim through the MHD online billing system;

(III) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(IV) The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment. Providers submitting crossover claims for Medicare Advantage outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

C. MHD reimbursement for approved outpatient hospital services. MHD will reimburse seventy-five percent (75%) of the allowable cost-sharing amount; and

D. MHD will continue to reimburse one hundred percent (100%) of the allowable cost-sharing amounts for outpatient services provided by public hospitals operated by DMH as set forth above in paragraph (1)(C)4.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 110—Division of Youth Services
Chapter 8—Youth Finances

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Division of Youth Services, under sections 219.036, 219.016, 219.091, and 660.017, RSMo 2016, the division adopts a rule as follows:

13 CSR 110-8.010 Division of Youth Services Trust Fund Program **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 1, 2019 (44 MoReg 565-566). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 110—Division of Youth Services
Chapter 8—Youth Finances

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Division of Youth Services, under sections 219.036, 219.016, 219.091, and 660.017, RSMo 2016, the division adopts a rule as follows:

13 CSR 110-8.020 Division of Youth Services Child Benefits Program **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on February 1, 2019 (44 MoReg 566-567). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

ORDER OF RULEMAKING

By the authority vested in the secretary of state under sections 181.021 and 181.060, RSMo 2016, the secretary amends a rule as follows:

15 CSR 30-200.010 State and Federal Grants—Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2019 (44 MoReg 921-922). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication

in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

ORDER OF RULEMAKING

By the authority vested in the secretary of state under sections 181.021 and 181.060, RSMo 2016, the secretary amends a rule as follows:

15 CSR 30-200.020 State and Other Grants-in-Aid **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2019 (44 MoReg 922-923). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

ORDER OF RULEMAKING

By the authority vested in the secretary of state under sections 181.021 and 181.060, RSMo 2016, the secretary amends a rule as follows:

15 CSR 30-200.025 Application and Payment Procedures for Appropriations or Grants **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2019 (44 MoReg 923). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

ORDER OF RULEMAKING

By the authority vested in the secretary of state under sections 181.021 and 181.060, RSMo 2016, the secretary amends a rule as follows:

15 CSR 30-200.030 Public Access Computers in Public Libraries **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2019 (44 MoReg 923-924). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

ORDER OF RULEMAKING

By the authority vested in the secretary of state under section 181.110, RSMo Supp. 2018, the secretary amends a rule as follows:

15 CSR 30-200.100 State Publications Access Program **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 15, 2019 (44 MoReg 924-925). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 3—Rules Applying to Political Subdivisions

ORDER OF RULEMAKING

By the authority vested in the Missouri State Auditor's Office under sections 29.100 and 137.073.6, RSMo 2016, the auditor amends a rule as follows:

15 CSR 40-3.125 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 792-811). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The State Auditor's Office staff submitted two (2) comments. No other comments were received.

COMMENT #1: The staff of the State Auditor's Office made one (1) comment regarding Form A and Informational Form A in section (3). The comment related to changing a typographical error, specifically to change the equation on Line 21b to a minus sign rather than a plus sign. The equation will be (Line 21 - Line 21a) rather than (Line 21 + Line 21a).
RESPONSE AND EXPLANATION OF CHANGE: The forms will be amended to reflect these changes.

COMMENT #2: The staff of the State Auditor's Office made one (1) comment regarding Form C in section (2) and section (3). The comment related to removing Lines 8a and 8b and revising Line 9 to state (line 7 - Line 8) rather than (Line 7 - Line 8b). This revision is because school districts cannot provide a prior year state assessed revenue received from debt service amount to net the estimated state assessed revenue from debt service in order to come up with a new

construction amount.
RESPONSE AND EXPLANATION OF CHANGE: The forms will be amended to reflect these changes.

15 CSR 40-3.125 Calculation and Revision of Property Tax Rates by School Districts

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form C (20__)

For School Districts Levying a Single Rate on All Property

Name of Political Subdivision	Political Subdivision Code	Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Debt Service Calculation for General Obligation Bonds Paid for with Property Taxes

The tax rate for debt service will be considered valid if, after making the payment(s) for which the tax was levied, the bonds remain outstanding, and the debt fund reserves do not exceed the following year's payments.

Since the property taxes are levied and collected on a calendar year basis (January - December), it is recommended that this levy be computed using calendar year data.

1. **Total current year assessed valuation** obtained from the county clerk or county assessor (Form A, Line 1 total) _____
2. **Amount required to pay debt serive requirements during the next calendar year** (i.e. Assuming the current year is year 1, use January - December year 2 payments to complete the year 1 Form C) Include the principal and interest payments due on outstanding general obligation bond issues plus anticipated fees of any transfer agent or paying agent due during the next calendar year. _____
3. **Estimated costs of collection and anticipated delinquencies (i.e. collector fees & commissions & assessment fund withholdings)** Experience in prior years is the best guide for estimating uncollectible taxes. It is usually 2% to 10% of Line 2 above. _____
4. **Reasonable reserve up to one year's payment** (i.e. Assuming the current year is year 1, use January - December year 3 payments to complete the year 1 Form C) It is important that the debt service fund have sufficient reserves to prevent any default on the bonds. Include payments for the year following the next calendar year, accounted for on Line 2. _____
5. **Total required for debt service** (Line 2 + Line 3 + Line 4) _____
6. **Anticipated balance at end of current calendar year** Show the anticipated bank or fund balance at December 31st of this year (this will equal the current balance minus the amount of any principal or interest due before December 31st plus any estimated investment earning due before December 31st). Do not add the anticipated collections of this tax into this amount. _____
7. **Property tax revenue required for debt service** (Line 5 - Line 6) Line 6 is subtracted from Line 5 because, the debt service fund is only allowed to have the payments required for the next calendar year (Line 2) and the reasonable reserve of the following year's payment (Line 4). Any current balance in the fund is already available to meet these requirements so it is deducted from the total revenues required for debt service purposes. _____
8. **Estimated revenue from state assessed property for debt service for the next calendar year (January - December)** - must be estimated by the school district. In most instances a good estimate would be the same amount as the state assessed revenues actually placed in the debt service fund in the prior year. _____
9. **Revenue required from locally assessed property for debt service** (Line 7 - Line 8) _____
10. **Computation of debt service tax rate** (Line 9 / Line 1 x 100) Round a fraction to the nearest one/one hundredth of a cent. _____
11. **Less voluntary reduction by school district** _____
12. **Actual rate to be levied for debt service purposes * (Line 10 - Line 11)** **Enter this rate on Line AA of the Summary Page** _____

* The tax rate levied may be lower than the rate computed as long as adequate funds are available to service the debt requirements.

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision _____ Political Subdivision Code _____ Purpose of Levy _____

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

Information on this page takes into consideration any voluntary reduction(s) taken in previous even numbered year(s). If in an even numbered year, the political subdivision wishes to no longer use the lowered tax rate ceiling to calculate its tax rate, it can hold a public hearing and pass a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate. The information on the Informational Summary Page, at the end of these forms, provides the rate that would be allowed had there been no previous voluntary reduction(s) taken in an even numbered year(s).

		(a)	(b) Real Estate		(c)	(d)		
		Residential	Agricultural	Commercial	Personal Property	Total	Prior Method Single Rate
1.	**(20__) Current year assessed valuation** Include the current locally assessed valuation obtained from the county clerk, county assessor, or comparable office finalized by the local board of equalization.						
2.	**Assessed valuation of new construction & improvements** 2(a) (b) & (c) - May be obtained from the county clerk or county assessor. 2(d) = Line 1(d) - 3(d) - 6(d) - 7(d) - 8(d), if negative, enter 0						
3	**Assessed value of newly added territory** obtained from the county clerk or county assessor						
4.	**Assessed value of real property that changed subclass from the prior year and was added to a new subclass in the current year** obtained from the county clerk or county assessor						
5.	**Adjusted current year assessed valuation** (Line 1 - Line 2 - Line 3 - Line 4)						
6.	**(20__) Prior year assessed valuation** Include the prior year locally assessed valuation obtained from the county clerk, county assessor, or comparable office finalized by the local board of equalization. NOTE: If this is different than the amount on the prior year Form A, Line 1 then revise the prior year tax rate form to recalculate the prior year tax rate ceiling. Enter the revised prior year tax rate ceiling on the current year's Summary Page, Line A						
7.	**Assessed value in newly separated territory** obtained from the county clerk or county assessor						
8.	**Assessed value of property locally assessed in prior year, but state assessed in current year** obtained from the county clerk or county assessor						
9.	**Assessed value of real property that changed subclass from the prior year and was subtracted from the previously reported subclass** obtained from the county clerk or county assessor						
10.	**Adjusted prior year assessed valuation** (Line 6 - Line 7 - Line 8 - Line 9)						

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

Information on this page takes into consideration any voluntary reduction(s) taken in previous even numbered year(s). If in an even numbered year, the political subdivision wishes to no longer use the lowered tax rate ceiling to calculate its tax rate, it can hold a public hearing and pass a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate. The information on the Informational Summary Page, at the end of these forms, provides the rate that would be allowed had there been no previous voluntary reduction(s) taken in an even numbered year(s).

		(a)	(b)	(c)	(d)		
		Real Estate			Personal		Prior Method
		Residential	Agricultural	Commercial	Property	Total	Single Rate
11.	**Percentage increase in adjusted valuation** of existing property in the current year over the prior year's assessed valuation (Line 5 - Line 10 / Line 10 x 100)						
12.	**Increase in Consumer Price Index (CPI)** certified by the State Tax Commission						
13.	**Adjusted prior year assessed valuation** (Line 10)						
14.	**(20__) Prior year voluntarily reduced rate in non-reassessment year** (Summary Page, Line A)						
15.	**Maximum prior year adjusted revenue permitted** from locally assessed property that existed in both years (Line 13 x Line 14 / 100)						
16.	**Maximum prior year revenue from state assessed property** before reductions, provided by DESE & allocated to each subclass of real estate based on its % of assessed valuation						
17.	**Total adjusted prior year revenue** (Line 15 + Line 16)						
18.	**Permitted reassessment revenue growth** Enter the lower of the actual growth (Line 11), the CPI (Line 12), or 5%. If Line 11 is negative, enter 0%. Do not enter less than 0%, nor more than 5%.						
19.	**Additional reassessment revenue permitted** (Line 17 x Line 18)						
20.	**Revenue permitted in the current year** from property that existed in both years (Line 17 + Line 19)						
21.	**Estimated current year revenue from state assessed property** before reductions The school district should use its best estimate for Line 21 total, which is allocated to each subclass of real estate based on its % of assessed valuation. (i.e. same amount as Line 16 total, Line 16 total multiplied by the % increase in state assessed valuation per the State Tax Commission, or using the best educated guess) If Line 21 total declines substantially from the amount on Line 16 total, please provide written documentation to the State Auditor's Office to explain the reasons for such difference.						
21a.	**New construction and improvements** (Line 21 - Line 16, if negative enter 0)						
21b.	**Adjusted estimated current year revenue from state assessed property** before reductions (Line 21 - Line 21a)						

(Form Revised 12-2018)

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision _____ Political Subdivision Code _____ Purpose of Levy _____

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

Information on this page takes into consideration any voluntary reduction(s) taken in previous even numbered year(s). If in an even numbered year, the political subdivision wishes to no longer use the lowered tax rate ceiling to calculate its tax rate, it can hold a public hearing and pass a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate. The information on the Informational Summary Page, at the end of these forms, provides the rate that would be allowed had there been no previous voluntary reduction(s) taken in an even numbered year(s).

	(a)	(b)	(c)	(d)		
	Real Estate					
	Residential	Agricultural	Commercial	Personal Property	Total	Prior Method Single Rate
22. **Revenue permitted from existing locally assessed property** (Line 20 - Line 21b)						
23. **Adjusted current year assessed valuation** (Line 5)						
24. **Tax rate permitted using prior method** tax rate permitted prior to HB 1150 & SB960 (Line 22 / Line 23 x 100)						
25. **Limit personal property to the prior year ceiling** (Lower of Line 24 personal property or Line 14 personal property)						
26. **Maximum authorized levy** (Summary Page, Line E)						
27. **Limit to the prior year maximum authorized levy** (Lower of Line 21 Line 25 for personal property only, or Line 26)						
Enter the rate for the prior method column on Line B of the Summary Page						
Calculate Revised Rate(s)						
28. **Tax revenue** (Line 1 x Line 27 / 100)						
29. **Total assessed valuation** (Line 1 total)						
30. **Blended rate** (Line 28 total / Line 29 x 100)						
31. **Revenue difference** due to the multi rate calculation (Line 28 total - Line 28 prior method)						
32. **Rate(s) to be revised** NOTE: Revision cannot increase personal property rate. (If Line 31 > 0 & Line 27 < Line 27 prior method, then Line 27, otherwise 0)						
33. **Current year adjusted assessed valuation** of the rates being revised (If Line 32 > 0, then Line 5, otherwise 0)						
34. **Relative ratio of current year adjusted assessed valuation** of the rates being revised (Line 33 / Line 33 total)						
35. **Revision to rate** (If Line 32 > 0, then Line 34 x Line 31 / Line 5 x 100 (limited to < Line 32), otherwise 0)						
36. **Revised rate** (Line 27 - Line 35)						
37. **Revised rate rounded** (If Line 36 < 1, then round to a 3 - digit rate, otherwise round to a 4 - digit rate)						

(Form Revised 12-2018)

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

Information on this page takes into consideration any voluntary reduction(s) taken in previous even numbered year(s). If in an even numbered year, the political subdivision wishes to no longer use the lowered tax rate ceiling to calculate its tax rate, it can hold a public hearing and pass a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate. The information on the Informational Summary Page, at the end of these forms, provides the rate that would be allowed had there been no previous voluntary reduction(s) taken in an even numbered year(s).

	(a)	(b)	(c)	(d)		
	Real Estate					
	Residential	Agricultural	Commercial	Personal Property	Total	Prior Method Single Rate
Calculate Final Blended Rate						
38. **Tax revenue** (Line 1 x Line 37 / 100)						
39. **Total assessed valuation** (Line 1 total)						
40. **Final blended rate** (Line 38 total / Line 39 x 100)						
41. **Tax rate(s) permitted** calculated pursuant to Article X, Section 22, and Section 137.073 RSMo (Line 37) **Enter rate(s) on the Summary Page, Line B**						
For Informational Purposes Only - Impact of the Multi Rate System						
42. **Revenue calculated using the multi rate method** (Line 41 x Line 1 / 100)						
43. **Revenue calculated using the single rate method** (Line 27 prior method x Line 1 / 100)						
44. **Revenue differences** using the different methods (Line 42 - Line 43)						
45. **Percent change** (Line 44 / Line 43)						
For Informational Purposes Only - Blended Rate Calculation						
46. **Tax rate ceiling** (Summary Page, Line F)						
47. **Allowable recoupment rate** (Summary Page, Line I)						
48. **DESE Screen 6 tax rate ceiling including recoupment** (Line 46 + Line 47)						
49. **Assessed valuation** (Line 1)						
50. **Revenue from DESE Screen 6 tax rate ceiling** (Line 48 x Line 49 / 100)						
51. **Blended tax rate ceiling** to report on DESE Screen 6 (Line 50 total / Line 49 total x 100)						
52. **Voluntary reduction** (Summary Page, Line H)						
53. **Unadjusted levy** (Line 48 - Line 52)						
54. **Assessed valuation** (Line 1)						
55. **Revenue from unadjusted levy** (Line 53 x Line 54 / 100)						
56. **Blended tax rate from the unadjusted levy** to report on DESE Screen 6 (Line 55 / Line 54 x 100)						
57. **Prop C reduction** (Summary Page, Line G)						
58. **Adjusted levy** (Line 53 - Line 57)						
59. **Assessed valuation** (Line 1)						
60. **Revenue from adjusted levy** (Line 58 x Line 59 / 100)						
61. **Blended tax rate from the adjusted levy** to report on DESE Screen 6 (Line 60 / Line 59 x 100)						

(Form Revised 12-2018)

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Form C (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Debt Service Calculation for General Obligation Bonds Paid for with Property Taxes

The tax rate for debt service will be considered valid if, after making the payment(s) for which the tax was levied, the bonds remain outstanding, and the debt fund reserves do not exceed the following year's payments.

Since the property taxes are levied and collected on a calendar year basis (January - December), it is recommended that this levy be computed using calendar year data.

1. **Total current year assessed valuation** obtained from the county clerk or county assessor (Form A, Line 1 total) _____

2. **Amount required to pay debt service requirements during the next calendar year** (i.e. Assuming the current year is year 1, use January - December year 2 payments to complete the year 1 Form C) Include the principal and interest payments due on outstanding general obligation bond issues plus anticipated fees of any transfer agency or paying agent due during the next calendar year. _____

3. **Estimated costs of collection and anticipated delinquencies (i.e. collector fees and commissions and assessment fund withholdings)** Experience in prior years is the best guide for estimating uncollectible taxes. It is 2% to 10% of Line 2 above. _____

4. **Reasonable reserve up to one year's payment** (i.e. Assuming the current year is year 1, use January - December year 3 payments to complete the year 1 Form C) It is important that the debt service fund have sufficient reserves to prevent any default on the bonds. Include payments for the year following the next calendar year, accounted for on Line 2. _____

5. **Total required for debt service** (Line 2 + Line 3 + Line 4) _____

6. **Anticipated balance at end of current calendar year** Show the anticipated bank or fund balance at December 31st of this year (this will equal the current balance minus the amount of any principal or interest due before December 31st plus any estimated investment earnings due before December 31st). Do not add the anticipated collections of this tax into this amount. _____

7. **Property tax revenue required for debt service** (Line 5 - Line 6) Line 6 is subtracted from Line 5 because the debt service fund is only allowed to have the payments required for the next calendar year (Line 2) and the reasonable reserve of the following year's payments (Line 4). Any current balance in the fund is already available to meet these requirements, so it is deducted from the total revenues required for debt service purposes. _____

8. **Estimated revenue from state assessed property for debt service for the next calendar year (January - December)** - must be estimated by the school district. In most instances a good estimate would be the same amount as the state assessed revenues actually placed in the debt service fund in the prior year. _____

9. **Revenue required from locally assessed property for debt service** (Line 7 - Line 8) _____

10. **Computation of debt service tax rate** (Line 9 / Line 1 x 100) Round a fraction to the nearest one-one hundredth of a cent. _____

11. **Less voluntary reduction** by political subdivision _____

12. **Actual rate to be levied for debt service purposes** * (Line 10 - Line 11) **Enter this rate on the Summary Page, Line AA** _____

* The tax rate levied may be lower than the rate computed as long as adequate funds are available to service the debt requirements.

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Informational Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

This form shows the information that would have been on the line items for the Form A had no voluntary reductions(s) been taken in prior even numbered year(s). The information on this form should not be used in the current year unless the taxing authority wishes to reverse any voluntary reduction(s) taken in prior even numbered year(s) and follows the following steps in an even numbered year.
Step 1 - The governing body should hold a public hearing and adopt a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate.
Step 2 - Submit a copy of the resolution, policy, statement, or ordinance to the State Auditor's Office for review.

		(a)	(b)	(c)	(d)		
		Real Estate			Personal		Prior Method
		Residential	Agricultural	Commercial	Property	Total	Single Rate
1.	**(20__) Current year assessed valuation** Include the current locally assessed valuation obtained from the county clerk, county assessor, or comparable office finalized by the local board of equalization.						
2.	**Assessed valuation of new construction & improvements** 2(a) (b) & (c) - May be obtained from the county clerk or county assessor. 2(d) = Line 1(d) - 3(d) - 6(d) + 7(d) - 8(d). if negative, enter 0						
3.	**Assessed value of newly added territory** obtained from the county clerk or county assessor						
4.	**Assessed value of real property that changed subclass from the prior year and was added to a new subclass in the current year** obtained from the county clerk or county assessor						
5.	**Adjusted current year assessed valuation** (Line 1 - Line 2 - Line 3 - Line 4)						
6.	**(20__) Prior year assessed valuation** Include the prior year locally assessed valuation obtained from the county clerk, county assessor, or comparable office finalized by the local board of equalization, NOTE: If this is different than the amount on the prior year Informational Form A, Line 1 then revise the prior year tax rate form to recalculate the prior year tax rate ceiling. Enter the revised prior year tax rate ceiling on the current year's Informational Summary Page, Line A.						
7.	**Assessed value in newly separated territory** obtained from the county clerk or county assessor						
8.	**Assessed value of property locally assessed in prior year, but state assessed in current year** obtained from the county clerk or county assessor						
9.	**Assessed value of real property that changed subclass from the prior year and was subtracted from the previously reported subclass** obtained from the county clerk or county assessor						
10.	**Adjusted prior year assessed valuation** (Line 6 - Line 7 - Line 8 - Line 9)						

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Informational Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

This form shows the information that would have been on the line items for the Form A had no voluntary reductions(s) been taken in prior even numbered year(s). The information on this form should not be used in the current year unless the taxing authority wishes to reverse any voluntary reduction(s) taken in prior even numbered year(s) and follows the following steps in an even numbered year.
Step 1 - The governing body should hold a public hearing and adopt a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate.
Step 2 - Submit a copy of the resolution, policy, statement, or ordinance to the State Auditor's Office for review.

		(a)	(b)	(c)	(d)		
		Real Estate			Personal		Prior Method
		Residential	Agricultural	Commercial	Property	Total	Single Rate
11.	**Percentage increase in adjusted valuation** of existing property in the current year over the prior year's assessed valuation (Line 5 - Line 10 / Line 10 x 100)						
12.	**Increase in Consumer Price Index (CPI)** certified by the State Tax Commission						
13.	**Adjusted prior year assessed valuation** (Line 10)						
14.	**(20__) Prior year tax rate ceiling** (Informational Summary Page, Line A)						
15.	**Maximum prior year adjusted revenue permitted** from locally assessed property that existed in both years (Line 13 x Line 14 / 100)						
16.	**Maximum prior year revenue from state assessed property** before reductions, provided by the DESE & allocated to each subclass of real estate based on its % of assessed valuation						
17.	**Total adjusted prior year revenue** (Line 15 + Line 16)						
18.	**Permitted reassessment revenue growth** Enter the lower of the actual growth (Line 11), the CPI (Line 12), or 5%. If Line 11 is negative, enter 0%. Do not enter less than 0%, nor more than 5%.						
19.	**Additional reassessment revenue permitted** (Line 17 x Line 18)						
20.	**Revenue permitted in the current year** from property that existed in both years (Line 17 + Line 19)						
21.	**Estimated current year revenue from state assessed property** before reductions The school district should use it's best estimate for Line 21 total, which is allocated to each subclass of real estate based on its % of assessed valuation. (i.e. same amount as Line 16 total, Line 16 total multiplied by the % increase in state assessed valuation per the State Tax Commission, or using the educated guess) If Line 21 total declines substantially from the amount on Line 16 total, please provide written documentation to the State Auditor's Office to explain the reasons for such difference.						
21a.	**New construction and improvements** (Line 21 - Line 16, if negative enter 0)						
21b.	**Adjusted estimated current year revenue from state assessed property** before reductions (Line 21 - Line 21a)						

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Informational Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision | Political Subdivision Code | Purpose of Levy

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

This form shows the information that would have been on the line items for the Form A had no voluntary reduction(s) been taken in prior even numbered year(s). The information on this form should not be used in the current year unless the taxing authority wishes to reverse any voluntary reduction(s) taken in prior even numbered year(s) and follows the following steps in an even numbered year.
Step 1 - The governing body should hold a public hearing and adopt a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate.
Step 2 - Submit a copy of the resolution, policy, statement, or ordinance to the State Auditor's Office for review.

	(a)	(b)	(c)	(d)		
	Real Estate			Personal		Prior Method
	Residential	Agricultural	Commercial	Property	Total	Single Rate
22. **Revenue permitted in the current year** from existing locally assessed property (Line 20 - Line 21b)						
23. **Adjusted current year assessed valuation** (Line 5)						
24. **Tax rate permitted using prior method** tax rate permitted prior to HB 1150 & SB960 (Line 22 / Line 23 x 100)						
25. **Limit personal property to the prior year ceiling** (Lower of Line 24 personal property or Line 14 personal property)						
26. **Maximum authorized levy** (Informational Summary Page, Line E)						
27. **Limit to the prior year maximum authorized levy** (Lower of Line 24, Line 25 (for personal property only), or Line 26)						

Enter the rate for prior method column on Line B of the Informational Summary Page.

Calculate Revised Rate(s)

28. **Tax revenue** (Line 1 x Line 27 / 100)						
29. **Total assessed valuation** (Line 1 total)						
30. **Blended rate** (Line 28 total / Line 29 x 100)						
31. **Revenue difference** due to the multi rate calculation (Line 28 total - Line 28 prior method)						
32. **Rate(s) to be revised** NOTE: Revision cannot increase personal property rate (If Line 31 < or > 0 & Line 27 < Line 27 prior method, then Line 27, otherwise 0)						
33. **Current year adjusted assessed valuation** of the rates being revised (If Line 32 > 0, then Line 5, otherwise 0)						
34. **Relative ratio of current year adjusted assessed valuation** of the rates being revised (Line 33 / Line 33 total)						
35. **Revision to rate** (If Line 32 > 0, then Line 34 x Line 31 / Line 5 x 100 (limited to < Line 32), otherwise 0)						
36. **Revised rate** (Line 27 + Line 35)						
37. **Revised rate rounded** (If Line 36 < 1, then round to a 3 - digit rate, otherwise round to a 4-digit rate)						

PRO FORMA - STATE AUDITOR'S REVIEW OF DATA SUBMITTED

Informational Form A (20__)

For School Districts Calculating a Separate Rate on Each Subclass of Property

Name of Political Subdivision _____ Political Subdivision Code _____ Purpose of Levy _____

The final version of this form MUST be sent to the county clerk.

Computation of reassessment growth and rate for compliance with Article X, Section 22, and Section 137.073, RSMo.

This form shows the information that would have been on the line items for the Form A had no voluntary reductions(s) been taken in prior even numbered year(s). The information on this form should not be used in the current year unless the taxing authority wishes to reverse any voluntary reduction(s) taken in prior even numbered year(s) and follows the following steps in an even numbered year.
Step 1 - The governing body should hold a public hearing and adopt a resolution, a policy statement, or an ordinance justifying its action prior to setting and certifying its tax rate.
Step 2 - Submit a copy of the resolution, policy, statement, or ordinance to the State Auditor's Office for review.

	(a)	(b)	(c)	(d)		
	Real Estate			Personal		Prior Method
	Residential	Agricultural	Commercial	Property	Total	Single Rate
Calculate Final Blended Rate						
38. **Tax revenue** (Line 1 x Line 37 / 100)						
39. **Total assessed valuation** (Line 1 total)						
40. **Final blended rate** (Line 38 total / Line 39 x 100)						
41. **Tax rate(s) permitted** calculated pursuant to Article X, Section 22, and Section 137.073, RSMo (Line 37) **Enter Rate(s) on the Informational Summary Page, Line B**						
For Information Purposes Only - Impact of the Multi Rate System						
42. **Revenue calculated using the multi rate method** (Line 41 x Line 1) / 100)						
43. **Revenue calculated using the single rate method** (Line 27 prior method x Line 1 / 100)						
44. **Revenue differences using the different methods** (Line 42 - Line 43)						
45. **Percent change** (Line 44 / Line 43)						
For Information Purposes Only - Blended Rate Calculation						
46. **Tax rate ceiling** (Informational Summary Page, Line F)						
47. **Allowable recoupment rate** (Summary Page, Line I)						
48. **DESE Screen 6 tax rate ceiling including recoupment** (Line 46 + Line 47)						
49. **Assessed valuation** (Line 1)						
50. **Revenue from DESE Screen 6 tax rate ceiling** (Line 48 x Line 49 / 100)						
51. **Blended tax rate ceiling** to report on DESE Screen 6 (Line 50 total / Line 49 total x 100)						
52. **Voluntary reduction** (Summary Page, Line H)						
53. **Unadjusted levy** (Line 48 - Line 52)						
54. **Assessed valuation** (Line 1)						
55. **Revenue from unadjusted levy** (Line 53 x Line 54 / 100)						
56. **Blended tax rate from the unadjusted levy** to report on DESE Screen 6 (Line 55 / Line 54 x 100)						
57. **Prop C reduction** (Summary Page, Line G)						
58. **Adjusted levy** (Line 53 - Line 57)						
59. **Assessed valuation** (Line 1)						
60. **Revenue from adjusted levy** (Line 58 x Line 59 / 100)						
61. **Blended tax rate from the adjusted levy** to report on DESE Screen 6 (Line 60 / Line 59 x 100)						

Title 15—ELECTED OFFICIALS
Division 40—State Auditor
Chapter 3—Rules Applying to Political Subdivisions

ORDER OF RULEMAKING

By the authority vested in the Missouri State Auditor's Office under sections 29.100 and 137.073.6, RSMo 2016, the auditor amends a rule as follows:

15 CSR 40-3.135 Calculation and Revision of Property Tax Rates by Political Subdivisions Other Than School Districts **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 811-817). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 25—Missouri State Public Health Laboratory
Chapter 36—Testing for Metabolic Diseases

ORDER OF RULEMAKING

By the authority vested in the Missouri Department of Health and Senior Services under sections 191.331 and 192.006, RSMo 2016, and section 191.332, RSMo Supp. 2017, the department amends a rule as follows:

19 CSR 25-36.010 Testing for Metabolic and Genetic Disorders **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on March 1, 2019 (44 MoReg 817-819). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 197.005 and 197.080, RSMo Supp. 2017, and section 536.031, RSMo Supp. 2018, the department adopts a rule as follows:

19 CSR 30-20.013 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on March 15, 2019 (44 MoReg 925). The authority section is being changed, and that is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The department received two (2) comments on the proposed rule, one (1) proposing a change to the text of the rule and one (1) regarding the authority section.

COMMENT #1: The Missouri Hospital Association (MHA) provided a comment applicable to each of three (3) components of the proposed rule, which address critical access hospitals, hospitals, and psychiatric hospitals. Specifically, the comment applies to the last sentence of subsections (A), (B) and (C) of the rule; MHA recommends the last sentence should read "Missouri licensed hospitals shall comply with the standards and CMS enforcement interpretations of the Medicare Conditions of Participation and surveys shall be conducted per Medicare standards pursuant to section 197.005, RSMo." MHA asserts that this change "would most accurately reflect the intent of [section 197.005, RSMo] and communicate a clear direction for both surveyors and providers moving forward."
RESPONSE: Although CMS enforcement interpretations, such as those in the State Operations Manual, may serve as guidance in applying the standards, the rule does not incorporate the enforcement interpretations. Section 536.031, RSMo would not permit later additions or amendments of the enforcement interpretations to be incorporated by reference. Because the proposed rule does not incorporate CMS's enforcement interpretations, the department does not believe that the rule should be changed to include enforcement interpretations. If, on the other hand, MHA means by "enforcement interpretations" that the department must in every case, for state-licensure purposes, abide by CMS's determinations of whether hospitals meet the Medicare Conditions of Participation, this would appear to conflict with section 197.100.1, RSMo, which gives the department the sole authority and responsibility for licensure of hospitals in this state. Under section 197.005, RSMo, in relevant part, "compliance with Medicare conditions of participation shall be deemed to constitute compliance with the standards for hospital licensure under sections 197.010 to 197.120 and regulations promulgated thereunder." The department believes that the last sentences of the rule at issue as presently written—stating that "Missouri licensed [critical access hospitals, hospitals, and psychiatric hospitals] shall strictly meet the *Medicare Conditions of Participation* and surveys performed for state licensure will be conducted per Medicare standards"—are in accordance with section 197.005, RSMo's intent. Therefore, the rule will not be changed as proposed.

COMMENT #2: Staff from the department commented that statutory authority for the rule in the authority section should be sections 197.005, 197.080, and 536.031, RSMo, not section 197.297, RSMo.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees that the authority section should be changed as proposed.

19 CSR 30-20.013 Incorporation of Medicare Conditions of Participation

AUTHORITY: sections 197.005 and 197.080, RSMo Supp. 2017, and section 536.031, RSMo Supp. 2018. Emergency rule filed Feb. 14, 2019, effective Feb. 24, 2019, expires Aug. 22, 2019. Original rule filed Feb. 14, 2019.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2231—Division of Professional Registration
Chapter 1—Organization and Description of Division

ORDER OF RULEMAKING

By the authority vested in the Division of Professional Registration under section 324.001, RSMo Supp. 2018, the division amends a

rule as follows:

20 CSR 2231-1.010 General Organization **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 702). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2231—Division of Professional Registration
Chapter 2—Designation of License Renewal Dates and Related Renewal Information

ORDER OF RULEMAKING

By the authority vested in the Division of Professional Registration under section 324.001, RSMo Supp. 2018, the division amends a rule as follows:

20 CSR 2231-2.010 Designation of License Renewal Dates and Related Renewal Information **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on February 15, 2019 (44 MoReg 702-703). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 340—Division of Energy
Chapter 2—Energy Loan Program

IN ADDITION

Notification: Applications accepted between June 17, 2019 and September 20, 2019 for Energy Efficiency and Renewable Energy Loan Cycle.

The Missouri Department of Economic Development's (department) Division of Energy is making available approximately four (4) million dollars in loan financing for qualified energy efficiency and renewable energy projects. Energy-saving investments may include projects such as insulation, lighting systems, heating and cooling systems, combined heat and power, pumps, motors, aerators, renewable energy systems, and other measures that reduce energy use and cost. Recipients repay loans with money saved on energy costs.

Eligible Energy-Using Sectors: Loan funds will be allocated to eligible energy-using sectors as follows:

- Public Schools (K-12): twenty-five percent (25%) of available funds;
- Public Higher Education Institutions: twenty-five percent (25%) of available funds;
- Public and Private not-for-profit Hospitals: twenty-five percent (25%) of available funds; and
- Local Governments: twenty-five percent (25%) of available funds. Local governments include a county, city, or village (which may include water treatment plants or waste water facilities), local government/public owned airport facilities (municipal, county, regional, and international); or any hospital district as defined in section 206.010, RSMo; or any sewer district as defined in section 249.010, RSMo; or any water supply districts as defined in section 247.010, RSMo; or any ambulance district as defined in section 190.010, RSMo; or any subdistrict of a zoological park and museum district as defined in section 184.352, RSMo.

Application Procedures: An application for loan funds may be submitted to the department for the purpose of financing all or a portion of the cost of implementing an energy-saving project.

Each applicant may apply for a loan not to exceed five hundred thousand dollars ($500,000). Loan applications will not be considered for less than ten thousand dollars ($10,000) or with a payback score of less than six (6) months.

If funds remain after review and priority ranking of applications, the department will consider awarding loans in excess of five hundred thousand dollars ($500,000).

Requests for loan financing must be made using the Division of Energy's Energy Loan Program Application Authorization Form, Fuel Use Summary Form, and Energy Conservation Measure Summary Form. Application forms and instructions are available on the department's website: https://energyloan.mo.gov.

The Application Authorization Form must be signed and dated by an authorized official. An authorized official is an individual with authority to obligate an eligible applicant to the terms of loan agreement and promissory note to repay loan proceeds.

A paper or electronic copy of the signed original Application Authorization Form and required documents may be submitted to the department's address below.

Applications received after September 20, 2019 will not be considered for a loan award for this FY2020 cycle but may be held for consideration during subsequent application cycles.

The department may request additional information as needed to determine the feasibility of a project, the project's estimated annual energy savings, and financial risks of a loan transaction. Also, an energy conservation measure has the potential of affecting other areas within the facility or system. Applicants must have no outstanding actions for violations of applicable federal, state, or local laws, ordinances, and rules.

Interest Rates: Loan principal plus two and three quarters percent (2.75%) interest is to be repaid to the department in semi-annual payments not to exceed a ten- (10-) year repayment period. An administrative fee of one percent (1%) of loan principal will be added to the repayment amount.

Selection Criteria: Recipients of loan financing will be determined on a competitive basis. Applications will be ranked based on the project's payback score, which is determined by dividing the cost to implement a project by the estimated yearly energy cost savings. Projects with the lowest payback score in each sector allocation will be funded until all available funds are allocated. If all funds are not allocated in any one (1) sector after ranking payback scores, the department may allocate funds to other sectors. ****Note**** Applicants with an open Energy Loan Program loan (under construction or in repayment) may be deemed ineligible if demand exceeds offering. Loan applications will be approved or disapproved by December 19, 2019.

For More Information Contact:

Missouri Department of Economic Development
Division of Energy
Attn: Loan Program Clerk
PO Box 1766
301 W. High, Ste. 720
Jefferson City, MO 65102

Phone: 1.855.522.2796
Email: energy@ded.mo.gov
Website: https://energyloan.mo.gov/

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 7—Rules Applicable to Owners or Operators of Hazardous Waste Facilities

Permit Modifications List Available Online

The Missouri Department of Natural Resources invites the public to

review the list of completed hazardous waste permit modifications for the 2018 calendar year. The permit modification list for calendar year 2018, as well as lists from previous years, is available online at dnr.mo.gov/env/hwp/permits/publications.htm.

Businesses actively treating, storing (for longer than allowed by the hazardous waste generator regulations), or disposing hazardous waste in Missouri must obtain a hazardous waste permit. These permits contain operating and closure requirements, as well as necessary post-closure, corrective action, and financial assurance requirements. The department or facility can make changes to the currently effective permit, allowing the facility to change or improve its operations or respond to new or changed regulatory requirements. Additional information and examples of significant permit modifications in Missouri are highlighted in the EPA publication, *Permit Modifications Report: Safeguarding the Environment in the Face of Changing Business Needs*, available online at epa.gov/hwpermitting/permit-modifications-report-safeguarding-environment-face-changing-business-needs.

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2016, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to adrules.dissolutions@sos.mo.gov.

NOTICE OF DISSOLUTION OF JACKSON MANOR, LLC

Effective February 7, 2019, Jackson Manor, LLC (the "Company") is dissolved. In accordance with Vernon's Annotated Missouri Statutes § 347.141, this notice is intended for entities and/or individuals with potential legal claims against the Company. If you believe you have a claim against the Company, please present them in accordance with the notice of winding up filed by the Company with the Missouri Secretary of State by mailing a notice of claim to Jackson Manor, LLC at Attn: Cecil Harper, 1052 Highland Colony Parkway, Suite 100, Ridgeland, Mississippi 39157 and include: your name and address, the amount of the claim, the basis of the claim, and any documentation of the claim. Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS AND CLAIMANTS AGAINST KCT INTERMODAL TRANSPORTATION CORPORATION

KCT Intermodal Transportation Corporation, a Missouri nonprofit public benefit corporation ("Corporation"), was dissolved on the 29th day of November, 2018, by filing Articles of Dissolution by Voluntary Action with the Missouri Secretary of State. In accordance with the filing of the Articles of Dissolution by Voluntary Action, and pursuant to the Revised Statutes of Missouri, any and all claims against Corporation should be sent by mail to 30 West Pershing Road, Kansas City, Missouri. Each claim should include the following:

(1) The name, address and telephone number of the claimant;

(2) The amount of the claim;

(3) The basis of the claim;

(4) The date the claim arose.

Any and all claims against Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of the publication of this Notice.

**NOTICE OF CORPORATE DISSOLUTION
TO ALL CREDITORS AND CLAIMANTS
AGAINST
FOUNDATION SAVING SIGHT**

Foundation Saving Sight, a Missouri nonprofit public benefit corporation ("Corporation"), was dissolved on the 24th day of April, 2019, by filing Articles of Dissolution by Voluntary Action with the Missouri Secretary of State. In accordance with the filing of the Articles of Dissolution by Voluntary Action, and pursuant to the Revised Statutes of Missouri, any and all claims against Corporation should be sent by mail to 10560 North Ambassador Drive, Suite 210, Kansas City, Missouri 64153. Each claim should include the following:

(1) The name, address and telephone number of the claimant;

(2) The amount of the claim;

(3) The basis of the claim;

(4) The date the claim arose.

Any and all claims against Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the date of the publication of this Notice.

Notice of Winding Up for Limited Liability Company

1. The name of the limited liability company is Eisenbeis-Wilkey Property Management II, LLC, Charter #LC001588371.

2. The articles of organization for the limited liability company were filed on the following date: April 21, 2018.

3. Persons with claims against the limited liability company should present them in accordance with the following procedure:

A. In order to file a claim with the limited liability company, you must furnish the following: (i) amount of the claim; (ii) basis for the claim; and (iii) documentation of the claim;

B. Claims must be mailed to: James M. Kreitler, P.O. Box 740, Hillsboro, MO 63050;

4. A claim against the limited liability company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

In affirmation thereof, the facts stated above are true and correct:

/s/James M. Kreitler 03-15-2019

/s/Brian Eisenbeis 03-15-2019

NOTICE OF DISSOLUTION OF AGI-JACKSON MANOR, INC.

Effective February 6, 2019, AGI-Jackson Manor, Inc. (the "Company") is dissolved. In accordance with Vernon's Annotated Missouri Statutes § 351.482, this notice is intended for entities and/or individuals with potential legal claims against the Company. If you believe you have a claim against the Company, please mail a notice of claim to the Company at Attn: Cecil Harper, 1052 Highland Colony Parkway, Suite 100, Ridgeland, Mississippi 39157 and include your name and address, the nature and details of the incident giving rise to the alleged claim, the date the incident allegedly occurred, any witness(es) to the alleged incident giving rise to the claim, any injuries and/or damages you allege arose out of the incident, and any other information that might be relevant to the Company in assessing such potential claims. Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF DISSOLUTION

Notice is hereby given that Liberty Shoal, LLC (the "Company") is dissolved effective May 2, 2019. The name of the Registered Agent of the Company is Brett A. Weis, 203 W. 22nd Street, Kearney, Nebraska 68848. Any person having claims against Liberty Shoal, LLC should present them to the Registered agent within five (5) years of the third publication of the Notice. Such claims should include the amount, date and description of items asked for on the claim.

NOTICE OF WINDING UP TO ALL CREDITORS AND CLAIMANTS AGAINST CONTRACTOR SUPPORT SERVICES, LLC

On May 7, 2019, Contractor Support Services, LLC, a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State, effective on the filing date.

All claims against Contractor Support Services, LLC must be mailed to Randell Wallace at 300 S. John Q. Hammons Parkway, Suite 800, Springfield, Missouri 65806. Each claim must include the name, phone number, and address of the claimant; the amount of the claim; the basis of the claim; the date(s) on which the event(s) on which the claim is based occurred; and any documentation related to the claim.

Any and all claims against Contractor Support Services, LLC will be barred unless a proceeding to enforce such claim is commenced within three (3) years after the date this notice is published.

**NOTICE OF WINDING UP AND DISSOLUTION
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
SIX INVESTORS, LLC**

Effective May 8, 2019, Six Investors, LLC, a Missouri limited liability company (the "***Company***"), filed its Notice of Winding Up with the Missouri Secretary of State. The Company requests that all persons and organizations who have claims against the Company present them immediately by letter to Robert J. Selsor, Esq., c/o Polsinelli PC, 100 S. Fourth Street, Suite 1000, St. Louis, MO, 63102. All claims **must** include the name and address of the claimant, the amount claimed, the basis for and a description of the claim, and include copies of any supporting documentation. Any and all claims against the Company will be barred unless a proceeding to enforce such claim is commenced within three (3) years after the publication of this notice.

**NOTICE TO
CREDITORS AND CLAIMANTS OF
BREATHE YOGA AND CYCLING, L.L.C.**

Breathe Yoga and Cycling, L.L.C., a Missouri Limited Liability Company has dissolved and is in the process of winding up its affairs. On May 11, 2019, the company filed Notice of Winding Up with the Secretary of State of Missouri. Any and all claims against the company may be sent to C.L. Lawwill, 3242 Starkville St., St. Charles MO 63301. Each claim should include the following: name, address, and telephone number of the claimant, amount of claim, basis of the claim, and documents related to the claim. Any and all claims against the company will be barred unless a proceeding to enforce the claim is commenced within three years after the date of this publication of this notice.

NOTICE OF DISSOLUTION TO ALL CREDITORS OF
AND CLAIMANTS AGAINST OM SHIV SAI, LLC

On May 10, 2019, OM SHIV SAI, LLC, a Missouri limited liability company, filed its Notice of Winding Up for the limited liability company with the Missouri Secretary of State.

All claims must include: the name, address and telephone number of the claimant; the amount claimed; the basis of the claim; the date(s) on which the events occurred which gave rise to the claim; and any copies of any other supporting date. Claims should be in writing and mailed to: William Petrus, Petrus Law Office, LLC, P.O. Box 148, Mount Vernon, MO 65712.

Any claims against OM SHIV SAI, LLC will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

Notice of Winding Up
To All Creditors of and
Claimants Against
Barry Pointe Office Park, LLC

On May 6, 2019, Barry Pointe Office Park, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State. The Notice of Winding Up was effective on May 13, 2019.

Said company requests that all persons and organizations who have claims against it present them immediately by letter to the company at:

Barry Pointe Office Park, LLC
C/o BridgeBuilder Tax + Legal Services, P.A. Attn: Philip Growney
9325 Pflumm Road
Lenexa, KS 66215

All claims must include the name and address of the claimant, the amount claimed, the basis for the claim, the date(s) on which the event(s) on which the claim is based occurred, the documentation of the claim, and a brief description of the nature of the debt or the basis for the claim.

NOTICE: Because of the dissolution of Barry Pointe Office Park, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date of the three notices authorized by statute, whichever is published last.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—43 (2018) and 44 (2019). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				43 MoReg 3648
1 CSR 10-5.010	Commissioner of Administration		43 MoReg 3208	44 MoReg 1184	
1 CSR 10-10.010	Commissioner of Administration		44 MoReg 673R		
1 CSR 20-5.010	Personnel Advisory Board and Division of Personnel		44 MoReg 673		
1 CSR 20-5.015	Personnel Advisory Board and Division of Personnel		44 MoReg 675R		
1 CSR 20-5.020	Personnel Advisory Board and Division of Personnel		44 MoReg 675		
1 CSR 20-5.025	Personnel Advisory Board and Division of Personnel		44 MoReg 676		
1 CSR 30-3.025	Division of Facilities Management, Design and Construction		44 MoReg 38	This Issue	
1 CSR 30-3.060	Division of Facilities Management, Design and Construction		44 MoReg 45R	This IssueR	
1 CSR 30-4.020	Division of Facilities Management, Design and Construction		44 MoReg 45	This Issue	
1 CSR 30-4.030	Division of Facilities Management, Design and Construction		44 MoReg 49R	This IssueR	
1 CSR 30-4.040	Division of Facilities Management, Design and Construction		44 MoReg 49R	This IssueR	
1 CSR 35-2.010	Division of Facilities Management		44 MoReg 50R	This IssueR	
1 CSR 35-2.020	Division of Facilities Management		44 MoReg 50R	This IssueR	
1 CSR 35-2.030	Division of Facilities Management		44 MoReg 50	This Issue	
1 CSR 35-2.040	Division of Facilities Management		44 MoReg 52R	This IssueR	
1 CSR 35-2.050	Division of Facilities Management		44 MoReg 52R	This IssueR	
	DEPARTMENT OF AGRICULTURE				
2 CSR 70-17.010	Plant Industries		44 MoReg 52	44 MoReg 1568	
2 CSR 70-17.020	Plant Industries		44 MoReg 53	44 MoReg 1574	
2 CSR 70-17.030	Plant Industries		44 MoReg 57	44 MoReg 1576	
2 CSR 70-17.040	Plant Industries		44 MoReg 59	44 MoReg 1576	
2 CSR 70-17.050	Plant Industries		44 MoReg 59	44 MoReg 1577	
2 CSR 70-17.060	Plant Industries		44 MoReg 60	44 MoReg 1577	
2 CSR 70-17.070	Plant Industries		44 MoReg 62	44 MoReg 1578	
2 CSR 70-17.080	Plant Industries		44 MoReg 65	44 MoReg 1581	
2 CSR 70-17.090	Plant Industries		44 MoReg 65	44 MoReg 1581	
2 CSR 70-17.100	Plant Industries		44 MoReg 68	44 MoReg 1581	
2 CSR 70-17.110	Plant Industries		44 MoReg 70	44 MoReg 1582	
2 CSR 70-17.120	Plant Industries		44 MoReg 71	44 MoReg 1583	
2 CSR 80-5.010	State Milk Board		44 MoReg 1022		
2 CSR 90-10.012	Weights, Measures and Consumer Protection		44 MoReg 1133		
2 CSR 90-10.130	Weights, Measures and Consumer Protection		44 MoReg 1133		
2 CSR 90-10.140	Weights, Measures and Consumer Protection		44 MoReg 1134		
2 CSR 90-10.145	Weights, Measures and Consumer Protection		44 MoReg 1134		
2 CSR 90-10.150	Weights, Measures and Consumer Protection		44 MoReg 1134		
2 CSR 90-10.155	Weights, Measures and Consumer Protection		44 MoReg 1135		
2 CSR 90-10.160	Weights, Measures and Consumer Protection		44 MoReg 1135		
2 CSR 90-10.165	Weights, Measures and Consumer Protection		44 MoReg 1136		
2 CSR 90-10.170	Weights, Measures and Consumer Protection		44 MoReg 1136		
2 CSR 90-10.175	Weights, Measures and Consumer Protection		44 MoReg 1137		
2 CSR 90-10.180	Weights, Measures and Consumer Protection		44 MoReg 1137		
2 CSR 90-38.010	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.020	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.030	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.040	Weights, Measures and Consumer Protection		43 MoReg 2013R		
2 CSR 90-38.050	Weights, Measures and Consumer Protection		43 MoReg 2013R		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-7.440	Conservation Commission		N.A.	44 MoReg 1390	
3 CSR 10-7.455	Conservation Commission				44 MoReg 445
3 CSR 10-9.110	Conservation Commission		44 MoReg 1022	This Issue	
3 CSR 10-9.220	Conservation Commission		44 MoReg 273	44 MoReg 1391	
3 CSR 10-10.743	Conservation Commission		44 MoReg 1023	This Issue	
3 CSR 10-11.115	Conservation Commission		44 MoReg 1023	This Issue	
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 85-5.010	Division of Business and Community Services	44 MoReg 1229	44 MoReg 1248		
4 CSR 85-5.020	Division of Business and Community Services	44 MoReg 1230	44 MoReg 1249		
4 CSR 85-5.030	Division of Business and Community Services	44 MoReg 1232	44 MoReg 1251		
4 CSR 85-5.040	Division of Business and Community Services	44 MoReg 1233	44 MoReg 1252		
4 CSR 85-5.050	Division of Business and Community Services	44 MoReg 1233	44 MoReg 1252		
4 CSR 85-5.060	Division of Business and Community Services	44 MoReg 1234	44 MoReg 1253		
4 CSR 85-5.070	Division of Business and Community Services	44 MoReg 1234	44 MoReg 1253		
4 CSR 85-5.080	Division of Business and Community Services	44 MoReg 1235	44 MoReg 1253		
4 CSR 85-5.090	Division of Business and Community Services	44 MoReg 1235	44 MoReg 1254		
4 CSR 85-5.100	Division of Business and Community Services	44 MoReg 1236	44 MoReg 1254		
4 CSR 85-5.110	Division of Business and Community Services	44 MoReg 1237	44 MoReg 1255		
4 CSR 240-2.010	Public Service Commission		43 MoReg 3762	44 MoReg 1584	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 240-2.070	Public Service Commission		43 MoReg 3762	44 MoReg 1584	
4 CSR 240-2.120	Public Service Commission		43 MoReg 3763	44 MoReg 1585	
4 CSR 240-2.205	Public Service Commission		43 MoReg 3763	44 MoReg 1585	
4 CSR 240-3.010	Public Service Commission		43 MoReg 3764	44 MoReg 1585	
4 CSR 240-3.015	Public Service Commission		43 MoReg 3764R	44 MoReg 1586R	
4 CSR 240-3.020	Public Service Commission		43 MoReg 3764R	44 MoReg 1586R	
4 CSR 240-3.025	Public Service Commission		43 MoReg 3765R	44 MoReg 1586R	
4 CSR 240-3.030	Public Service Commission		43 MoReg 3765	44 MoReg 1587	
4 CSR 240-3.145	Public Service Commission		43 MoReg 3766R	44 MoReg 1587R	
4 CSR 240-3.180	Public Service Commission		43 MoReg 3766R	44 MoReg 1588R	
4 CSR 240-3.185	Public Service Commission		43 MoReg 3766R	44 MoReg 1588R	
4 CSR 240-3.235	Public Service Commission		44 MoReg 71R	44 MoReg 1589R	
4 CSR 240-3.250	Public Service Commission		43 MoReg 3767R	44 MoReg 1589R	
4 CSR 240-3.260	Public Service Commission		44 MoReg 71R	44 MoReg 1589R	
4 CSR 240-3.275	Public Service Commission		44 MoReg 72R	44 MoReg 1590R	
4 CSR 240-10.020	Public Service Commission		43 MoReg 3767	44 MoReg 1590	
4 CSR 240-10.040	Public Service Commission		43 MoReg 3768	44 MoReg 1590	
4 CSR 240-13.010	Public Service Commission		43 MoReg 3768	44 MoReg 1590	
4 CSR 240-13.015	Public Service Commission		43 MoReg 3769	44 MoReg 1591	
4 CSR 240-13.020	Public Service Commission		43 MoReg 3769	44 MoReg 1591	
4 CSR 240-13.025	Public Service Commission		43 MoReg 3770	44 MoReg 1592	
4 CSR 240-13.030	Public Service Commission		43 MoReg 3770	44 MoReg 1592	
4 CSR 240-13.050	Public Service Commission		43 MoReg 3770	44 MoReg 1593	
4 CSR 240-13.055	Public Service Commission		43 MoReg 3773	44 MoReg 1593	
4 CSR 240-13.070	Public Service Commission		43 MoReg 3774	44 MoReg 1594	
4 CSR 240-20.070	Public Service Commission		43 MoReg 3774	44 MoReg 1594	
4 CSR 240-20.100	Public Service Commission		44 MoReg 1024		
4 CSR 240-20.105	Public Service Commission		43 MoReg 3776	44 MoReg 1595	
4 CSR 240-40.033	Public Service Commission	44 MoReg 493	44 MoReg 500	This Issue	
4 CSR 240-40.085	Public Service Commission		44 MoReg 72	44 MoReg 1598	
4 CSR 240-40.090	Public Service Commission		44 MoReg 73	44 MoReg 1599	
4 CSR 340-2	Division of Energy				This Issue
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.120	Division of Learning Services		43 MoReg 3779R	44 MoReg 1333R	
5 CSR 20-100.190	Division of Learning Services		43 MoReg 3780	44 MoReg 1392	
5 CSR 20-100.230	Division of Learning Services		44 MoReg 678		
5 CSR 20-100.260	Division of Learning Services		44 MoReg 74	44 MoReg 1392	
5 CSR 20-100.300	Division of Learning Services *(Changed from 5 CSR 20-600.120)*				43 MoReg 3651
5 CSR 20-100.310	Division of Learning Services *(Changed from 5 CSR 20-600.130)*				43 MoReg 3651
5 CSR 20-100.320	Division of Learning Services *(Changed from 5 CSR 20-600.140)*				43 MoReg 3651
5 CSR 20-100.330	Division of Learning Services *(Changed from 5 CSR 20-600.110)*		44 MoReg 79	44 MoReg 1333	
5 CSR 20-300.110	Division of Learning Services		N.A.	This Issue	
5 CSR 20-400.220	Division of Learning Services		This Issue		
5 CSR 20-400.250	Division of Learning Services		44 MoReg 774R		
5 CSR 20-400.280	Division of Learning Services		44 MoReg 774R		
5 CSR 20-400.540	Division of Learning Services		44 MoReg 679		
5 CSR 20-500.110	Division of Learning Services		43 MoReg 3780R	44 MoReg 1334R	
5 CSR 20-600.110	Division of Learning Services *(Changed to 5 CSR 20-100.330)*		44 MoReg 79	44 MoReg 1333	
5 CSR 20-600.120	Division of Learning Services *(Changed to 5 CSR 20-100.300)*				43 MoReg 3651
5 CSR 20-600.130	Division of Learning Services *(Changed to 5 CSR 20-100.310)*				43 MoReg 3651
5 CSR 20-600.140	Division of Learning Services *(Changed to 5 CSR 20-100.320)*				43 MoReg 3651
5 CSR 30-261.010	Division of Financial and Administrative Services		44 MoReg 79	44 MoReg 1393	
	DEPARTMENT OF HIGHER EDUCATION				
6 CSR 10-2.080	Commissioner of Higher Education		44 MoReg 774	This Issue	
6 CSR 10-2.100	Commissioner of Higher Education		44 MoReg 775	This Issue	
6 CSR 10-2.120	Commissioner of Higher Education		44 MoReg 775	This Issue	
6 CSR 10-2.140	Commissioner of Higher Education		44 MoReg 776	This Issue	
6 CSR 10-2.150	Commissioner of Higher Education		44 MoReg 776	This Issue	
6 CSR 10-2.160	Commissioner of Higher Education		44 MoReg 777	This Issue	
6 CSR 10-2.170	Commissioner of Higher Education		44 MoReg 777	This Issue	
6 CSR 10-2.180	Commissioner of Higher Education		44 MoReg 777	This Issue	
6 CSR 10-2.190	Commissioner of Higher Education		44 MoReg 778	This Issue	
6 CSR 10-14.010	Commissioner of Higher Education		44 MoReg 1502		
	MISSOURI DEPARTMENT OF TRANSPORTATION				
7 CSR 10-4.020	Missouri Highways and Transportation Commission		44 MoReg 274	This Issue	
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 20-2.010	Labor and Industrial Relations Commission		44 MoReg 1377		
8 CSR 20-3.010	Labor and Industrial Relations Commission		44 MoReg 1378		
8 CSR 20-3.030	Labor and Industrial Relations Commission		44 MoReg 1380		
8 CSR 20-3.060	Labor and Industrial Relations Commission		44 MoReg 1381		
8 CSR 20-4.010	Labor and Industrial Relations Commission		44 MoReg 1382		
8 CSR 20-8.010	Labor and Industrial Relations Commission		44 MoReg 1383		
8 CSR 30-3.010	Division of Labor Standards	44 MoReg 5	44 MoReg 81	44 MoReg 1599	
8 CSR 30-3.030	Division of Labor Standards	44 MoReg 6	44 MoReg 82	44 MoReg 1601	
8 CSR 30-3.040	Division of Labor Standards	44 MoReg 7	44 MoReg 83	44 MoReg 1602	
8 CSR 30-3.050	Division of Labor Standards	44 MoReg 7	44 MoReg 83	44 MoReg 1602	
8 CSR 30-3.060	Division of Labor Standards	44 MoReg 8	44 MoReg 83	44 MoReg 1602	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF MENTAL HEALTH				
9 CSR 10-5.190	Director, Department of Mental Health		44 MoReg 779		
9 CSR 10-7.010	Director, Department of Mental Health		43 MoReg 3781	44 MoReg 1334	
9 CSR 10-7.020	Director, Department of Mental Health		43 MoReg 3786	44 MoReg 1334	
9 CSR 10-7.030	Director, Department of Mental Health		43 MoReg 3788	44 MoReg 1334	
9 CSR 10-7.040	Director, Department of Mental Health		43 MoReg 3794	44 MoReg 1335	
9 CSR 10-7.050	Director, Department of Mental Health		43 MoReg 3795	44 MoReg 1335	
9 CSR 10-7.080	Director, Department of Mental Health		43 MoReg 3796	44 MoReg 1335	
9 CSR 10-7.090	Director, Department of Mental Health		43 MoReg 3797	44 MoReg 1335	
9 CSR 10-7.100	Director, Department of Mental Health		43 MoReg 3799	44 MoReg 1335	
9 CSR 10-7.110	Director, Department of Mental Health		43 MoReg 3800	44 MoReg 1335	
9 CSR 10-7.120	Director, Department of Mental Health		43 MoReg 3802	44 MoReg 1336	
9 CSR 10-7.130	Director, Department of Mental Health		43 MoReg 3805	44 MoReg 1336	
9 CSR 30-3.160	Certification Standards		44 MoReg 1255		
9 CSR 30-3.230	Certification Standards		44 MoReg 781		
9 CSR 30-4.005	Certification Standards *(Changed from 9 CSR 30-4.042)*		44 MoReg 1516		
9 CSR 30-4.010	Certification Standards		44 MoReg 1505R		
9 CSR 30-4.020	Certification Standards		44 MoReg 1505R		
9 CSR 30-4.030	Certification Standards		44 MoReg 1505R		
9 CSR 30-4.031	Certification Standards		44 MoReg 1506R		
9 CSR 30-4.032	Certification Standards		44 MoReg 1506		
9 CSR 30-4.033	Certification Standards		44 MoReg 1507R		
9 CSR 30-4.034	Certification Standards		44 MoReg 1507		
9 CSR 30-4.035	Certification Standards		44 MoReg 1510		
9 CSR 30-4.038	Certification Standards		44 MoReg 1515R		
9 CSR 30-4.039	Certification Standards		44 MoReg 1515R		
9 CSR 30-4.040	Certification Standards		44 MoReg 1515R		
9 CSR 30-4.042	Certification Standards *(Changed to 9 CSR 30-4.005)*		44 MoReg 1516		
9 CSR 30-4.043	Certification Standards		44 MoReg 1520		
9 CSR 30-4.0431	Certification Standards		44 MoReg 1526		
9 CSR 30-4.0432	Certification Standards		44 MoReg 1528		
9 CSR 30-4.045	Certification Standards		44 MoReg 1533		
9 CSR 30-4.046	Certification Standards		44 MoReg 1536		
9 CSR 30-4.160	Certification Standards		44 MoReg 1539R		
9 CSR 30-4.190	Certification Standards		44 MoReg 1539		
9 CSR 30-4.195	Certification Standards		44 MoReg 1540		
9 CSR 30-6.010	Certification Standards	44 MoReg 1237	44 MoReg 1264		
9 CSR 45-3.010	Division of Developmental Disabilities		44 MoReg 784		
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-5.442	Air Conservation Commission		44 MoReg 1269		
10 CSR 10-5.550	Air Conservation Commission		44 MoReg 1272		
10 CSR 10-6.030	Air Conservation Commission		44 MoReg 1138		
10 CSR 10-6.050	Air Conservation Commission		44 MoReg 1543		
10 CSR 10-6.130	Air Conservation Commission		43 MoReg 1304		
10 CSR 10-6.140	Air Conservation Commission		44 MoReg 1544		
10 CSR 25-7	Hazardous Waste Management Commission				This Issue
10 CSR 60-15.020	Safe Drinking Water Commission		44 MoReg 1138		
10 CSR 80-2.010	Solid Waste Management		44 MoReg 501		
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 10-11.010	Adjutant General		44 MoReg 1025R		
11 CSR 10-11.020	Adjutant General		44 MoReg 1025R		
11 CSR 10-11.040	Adjutant General		44 MoReg 1026R		
11 CSR 10-11.050	Adjutant General		44 MoReg 1026R		
11 CSR 10-11.070	Adjutant General		44 MoReg 1026R		
11 CSR 10-11.090	Adjutant General		44 MoReg 1026R		
11 CSR 10-11.100	Adjutant General		44 MoReg 1027R		
11 CSR 10-11.110	Adjutant General		44 MoReg 1027R		
11 CSR 10-11.120	Adjutant General		44 MoReg 1027R		
11 CSR 30-1.010	Office of the Director		44 MoReg 1027		
11 CSR 30-1.050	Office of the Director		44 MoReg 1029R		
11 CSR 30-8.010	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.020	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.030	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.040	Office of the Director		43 MoReg 1328R		
11 CSR 30-9.010	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.020	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.030	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.040	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.050	Office of the Director		43 MoReg 1330R		
11 CSR 30-10.010	Office of the Director		44 MoReg 1029R		
11 CSR 30-16.010	Office of the Director		42 MoReg 180 44 MoReg 1029		
11 CSR 45-4.420	Missouri Gaming Commission		43 MoReg 3485	44 MoReg 1336	
11 CSR 45-5.190	Missouri Gaming Commission		44 MoReg 1547		
11 CSR 45-5.200	Missouri Gaming Commission		44 MoReg 1547		
11 CSR 45-5.210	Missouri Gaming Commission		44 MoReg 1550		
11 CSR 45-5.237	Missouri Gaming Commission		44 MoReg 1551		
11 CSR 45-7.130	Missouri Gaming Commission		43 MoReg 3485	44 MoReg 1336	
11 CSR 45-8.140	Missouri Gaming Commission		44 MoReg 1551		
11 CSR 45-9.102	Missouri Gaming Commission		43 MoReg 3486	44 MoReg 1336	
11 CSR 45-9.105	Missouri Gaming Commission		44 MoReg 1552		
11 CSR 45-9.106	Missouri Gaming Commission		43 MoReg 3486	44 MoReg 1336	
11 CSR 45-9.109	Missouri Gaming Commission		43 MoReg 3486	44 MoReg 1337	
11 CSR 45-9.116	Missouri Gaming Commission		43 MoReg 3487	44 MoReg 1337	
11 CSR 45-9.117	Missouri Gaming Commission		43 MoReg 3487	44 MoReg 1337	
11 CSR 45-12.020	Missouri Gaming Commission		44 MoReg 1552		
11 CSR 45-12.080	Missouri Gaming Commission		44 MoReg 1552		
11 CSR 45-30.020	Missouri Gaming Commission		43 MoReg 3488R	44 MoReg 1337R	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
11 CSR 45-40.030	Missouri Gaming Commission		43 MoReg 3488	44 MoReg 1337	
11 CSR 45-40.100	Missouri Gaming Commission		44 MoReg 1553		
11 CSR 50-2.010	Missouri State Highway Patrol		44 MoReg 681	This Issue	
11 CSR 50-2.030	Missouri State Highway Patrol		44 MoReg 682	This Issue	
11 CSR 50-2.100	Missouri State Highway Patrol		44 MoReg 682	This Issue	
11 CSR 50-2.110	Missouri State Highway Patrol		44 MoReg 683	This Issue	
11 CSR 50-2.335	Missouri State Highway Patrol		44 MoReg 683	This Issue	
11 CSR 50-3.010	Missouri State Highway Patrol *(Changed from 11 CSR 80-5.010)*		44 MoReg 917		
11 CSR 50-4.010	Missouri State Highway Patrol *(Changed from 11 CSR 80-9.010)*		44 MoReg 920		
11 CSR 50-5.010	Missouri State Highway Patrol *(Changed from 11 CSR 80-2.010)*		44 MoReg 915		
11 CSR 50-6.010	Missouri State Highway Patrol *(Changed from 11 CSR 80-3.010)*		44 MoReg 916		
11 CSR 50-7.010	Missouri State Highway Patrol *(Changed from 11 CSR 80-4.010)*		44 MoReg 916		
11 CSR 50-7.020	Missouri State Highway Patrol *(Changed from 11 CSR 80-7.010)*		44 MoReg 920		
11 CSR 70-2.240	Division of Alcohol and Tobacco Control	43 MoReg 3199	44 MoReg 787		
11 CSR 75-16.010	Peace Officer Standards and Training Program		44 MoReg 1139		
11 CSR 80-1.010	Missouri State Water Patrol		44 MoReg 915R		
11 CSR 80-2.010	Missouri State Water Patrol *(Changed to 11 CSR 50-5.010)*		44 MoReg 915		
11 CSR 80-3.010	Missouri State Water Patrol *(Changed to 11 CSR 50-6.010)*		44 MoReg 916		
11 CSR 80-3.020	Missouri State Water Patrol		44 MoReg 916R		
11 CSR 80-4.010	Missouri State Water Patrol *(Changed to 11 CSR 50-7.010)*		44 MoReg 916		
11 CSR 80-5.010	Missouri State Water Patrol *(Changed to 11 CSR 50-3.010)*		44 MoReg 917		
11 CSR 80-6.010	Missouri State Water Patrol		44 MoReg 919R		
11 CSR 80-7.010	Missouri State Water Patrol *(Changed to 11 CSR 50-7.020)*		44 MoReg 920		
11 CSR 80-8.010	Missouri State Water Patrol		44 MoReg 920R		
11 CSR 80-9.010	Missouri State Water Patrol *(Changed to 11 CSR 50-4.010)*		44 MoReg 920		
11 CSR 80-9.020	Missouri State Water Patrol		44 MoReg 921R		
	DEPARTMENT OF REVENUE				
12 CSR 10-2.015	Director of Revenue	44 MoReg 1493	44 MoReg 1553		
12 CSR 10-24.405	Director of Revenue		44 MoReg 789		
12 CSR 40-10.040	State Lottery		44 MoReg 274	44 MoReg 1393	
12 CSR 40-40.280	State Lottery		44 MoReg 275	44 MoReg 1393	
12 CSR 40-50.060	State Lottery		44 MoReg 275	44 MoReg 1393	
12 CSR 40-70.040	State Lottery		44 MoReg 275	44 MoReg 1393	
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 10-3.060	Division of Finance and Administrative Services		44 MoReg 789		
13 CSR 10-3.070	Division of Finance and Administrative Services		44 MoReg 791		
13 CSR 35-34.080	Children's Division		43 MoReg 3502	44 MoReg 1338	
13 CSR 40-2.180	Family Support Division		44 MoReg 1557		
13 CSR 40-13.010	Family Support Division		44 MoReg 1139		
13 CSR 40-13.015	Family Support Division		44 MoReg 1140		
13 CSR 40-13.020	Family Support Division		44 MoReg 1142		
13 CSR 40-110.030	Family Support Division		44 MoReg 1384		
13 CSR 65-3.010	Missouri Medicaid Audit and Compliance	44 MoReg 761			
13 CSR 70-3.280	MO HealthNet Division		44 MoReg 563	This Issue	
13 CSR 70-3.290	MO HealthNet Division		44 MoReg 564	This Issue	
13 CSR 70-3.310	MO HealthNet Division		This Issue		
13 CSR 70-6.010	MO HealthNet Division		This Issue		
13 CSR 70-10.016	MO HealthNet Division	This IssueT This Issue	This Issue		
13 CSR 70-10.110	MO HealthNet Division	This Issue	This Issue		
13 CSR 70-15.160	MO HealthNet Division		44 MoReg 685	This Issue	
13 CSR 70-20.320	MO HealthNet Division		44 MoReg 1557		
13 CSR 70-94.010	MO HealthNet Division		43 MoReg 3502	44 MoReg 1338	
13 CSR 110-3.030	Division of Youth Services		43 MoReg 3505	44 MoReg 1338	
13 CSR 110-7.010	Division of Youth Services		44 MoReg 97	44 MoReg 1338	
13 CSR 110-8.010	Division of Youth Services		44 MoReg 565	This Issue	
13 CSR 110-8.020	Division of Youth Services		44 MoReg 566	This Issue	
	ELECTED OFFICIALS				
15 CSR	Elected Officials				43 MoReg 1498
15 CSR 30-1.010	Secretary of State		44 MoReg 1276R		
15 CSR 30-14.010	Secretary of State	44 MoReg 1241	44 MoReg 1276		
15 CSR 30-45.010	Secretary of State		44 MoReg 1276R		
15 CSR 30-45.020	Secretary of State		44 MoReg 1276R		
15 CSR 30-200.010	Secretary of State		44 MoReg 921	This Issue	
15 CSR 30-200.020	Secretary of State		44 MoReg 922	This Issue	
15 CSR 30-200.025	Secretary of State	44 MoReg 897	44 MoReg 923	This Issue	
15 CSR 30-200.030	Secretary of State		44 MoReg 923	This Issue	
15 CSR 30-200.100	Secretary of State		44 MoReg 924	This Issue	
15 CSR 40-3.125	State Auditor		44 MoReg 792	This Issue	
15 CSR 40-3.135	State Auditor		44 MoReg 811	This Issue	
	RETIREMENT SYSTEMS				
16 CSR	Retirement Systems				43 MoReg 1498
16 CSR 10-3.020	The Public School Retirement Systems of Missouri		44 MoReg 686	44 MoReg 1603	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
16 CSR 10-5.010	The Public School Retirement Systems of Missouri		44 MoReg 686	44 MoReg 1603	
16 CSR 10-6.030	The Public School Retirement Systems of Missouri		44 MoReg 688	44 MoReg 1603	
16 CSR 10-6.060	The Public School Retirement Systems of Missouri		44 MoReg 688	44 MoReg 1603	
16 CSR 20-1.010	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
16 CSR 20-2.040	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
16 CSR 20-2.045	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
16 CSR 20-2.056	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
16 CSR 20-2.070	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
16 CSR 20-2.105	Missouri Local Government Employees' Retirement System (LAGERS)		This Issue		
	BOARD OF POLICE COMMISSIONERS				
17 CSR	Board of Police Commissioners				43 MoReg 1498
	PUBLIC DEFENDER COMMISSION				
18 CSR	Public Defender Commission				43 MoReg 1498
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 25-36.010	Missouri State Public Health Laboratory		44 MoReg 817	This Issue	
19 CSR 30-20.001	Division of Regulation and Licensure		44 MoReg 1277R		
19 CSR 30-20.011	Division of Regulation and Licensure		44 MoReg 1277		
19 CSR 30-20.013	Division of Regulation and Licensure	44 MoReg 897	44 MoReg 925	This Issue	
19 CSR 30-20.015	Division of Regulation and Licensure		44 MoReg 1280		
19 CSR 30-20.030	Division of Regulation and Licensure		44 MoReg 1288R 44 MoReg 1288		
19 CSR 30-20.040	Division of Regulation and Licensure		44 MoReg 1289R		
19 CSR 30-20.050	Division of Regulation and Licensure		44 MoReg 1289		
19 CSR 30-20.060	Division of Regulation and Licensure		44 MoReg 1293R		
19 CSR 30-20.080	Division of Regulation and Licensure		44 MoReg 1293R		
19 CSR 30-20.082	Division of Regulation and Licensure		44 MoReg 1293R		
19 CSR 30-20.084	Division of Regulation and Licensure		44 MoReg 1293R		
19 CSR 30-20.086	Division of Regulation and Licensure		44 MoReg 1294R		
19 CSR 30-20.088	Division of Regulation and Licensure		44 MoReg 1294R		
19 CSR 30-20.090	Division of Regulation and Licensure		44 MoReg 1294R		
19 CSR 30-20.092	Division of Regulation and Licensure		44 MoReg 1294		
19 CSR 30-20.094	Division of Regulation and Licensure		44 MoReg 1296R		
19 CSR 30-20.096	Division of Regulation and Licensure		44 MoReg 1296R		
19 CSR 30-20.097	Division of Regulation and Licensure		44 MoReg 1297R		
19 CSR 30-20.098	Division of Regulation and Licensure		44 MoReg 1297R		
19 CSR 30-20.100	Division of Regulation and Licensure		44 MoReg 1297R 44 MoReg 1297		
19 CSR 30-20.102	Division of Regulation and Licensure		44 MoReg 1299R		
19 CSR 30-20.104	Division of Regulation and Licensure		44 MoReg 1299R		
19 CSR 30-20.106	Division of Regulation and Licensure		44 MoReg 1299R		
19 CSR 30-20.108	Division of Regulation and Licensure		44 MoReg 1300R		
19 CSR 30-20.110	Division of Regulation and Licensure		44 MoReg 1300R		
19 CSR 30-20.112	Division of Regulation and Licensure		44 MoReg 1300R		
19 CSR 30-20.116	Division of Regulation and Licensure		44 MoReg 1300R		
19 CSR 30-20.118	Division of Regulation and Licensure		44 MoReg 1301R		
19 CSR 30-20.120	Division of Regulation and Licensure		44 MoReg 1301R		
19 CSR 30-20.124	Division of Regulation and Licensure		44 MoReg 1301R		
19 CSR 30-20.126	Division of Regulation and Licensure		44 MoReg 1301R		
19 CSR 30-20.128	Division of Regulation and Licensure		44 MoReg 1302R		
19 CSR 30-20.130	Division of Regulation and Licensure		44 MoReg 1302R		
19 CSR 30-20.132	Division of Regulation and Licensure		44 MoReg 1302R		
19 CSR 30-20.134	Division of Regulation and Licensure		44 MoReg 1302R		
19 CSR 30-20.136	Division of Regulation and Licensure		44 MoReg 1303R		
19 CSR 30-20.138	Division of Regulation and Licensure		44 MoReg 1303R		
19 CSR 30-20.140	Division of Regulation and Licensure		44 MoReg 1303R		
19 CSR 30-20.142	Division of Regulation and Licensure		44 MoReg 1303R		
19 CSR 30-24.010	Division of Regulation and Licensure		44 MoReg 1304R		
19 CSR 30-24.020	Division of Regulation and Licensure		44 MoReg 1304R		
19 CSR 30-24.030	Division of Regulation and Licensure		44 MoReg 1304R		
19 CSR 30-60.020	Division of Regulation and Licensure	44 MoReg 898	44 MoReg 925		
19 CSR 30-60.050	Division of Regulation and Licensure	44 MoReg 899	44 MoReg 926		
19 CSR 30-61.025	Division of Regulation and Licensure	44 MoReg 900	44 MoReg 927		
19 CSR 30-61.045	Division of Regulation and Licensure	44 MoReg 901	44 MoReg 928		
19 CSR 30-61.055	Division of Regulation and Licensure	44 MoReg 901	44 MoReg 930		
19 CSR 30-61.105	Division of Regulation and Licensure	44 MoReg 903	44 MoReg 931		
19 CSR 30-61.210	Division of Regulation and Licensure	44 MoReg 904	44 MoReg 934		
19 CSR 30-62.032	Division of Regulation and Licensure	44 MoReg 905	44 MoReg 935		
19 CSR 30-62.042	Division of Regulation and Licensure	44 MoReg 905	44 MoReg 935		
19 CSR 30-62.052	Division of Regulation and Licensure	44 MoReg 906	44 MoReg 938		
19 CSR 30-62.102	Division of Regulation and Licensure	44 MoReg 907	44 MoReg 939		
19 CSR 30-62.222	Division of Regulation and Licensure	44 MoReg 909	44 MoReg 942		
19 CSR 30-63.010	Division of Regulation and Licensure	44 MoReg 910	44 MoReg 943		
19 CSR 30-63.020	Division of Regulation and Licensure	44 MoReg 911	44 MoReg 944		
19 CSR 30-63.030	Division of Regulation and Licensure	44 MoReg 911	44 MoReg 950		
19 CSR 30-63.040	Division of Regulation and Licensure	44 MoReg 912	44 MoReg 950		
19 CSR 30-63.050	Division of Regulation and Licensure	44 MoReg 913	44 MoReg 950		
19 CSR 60-50	Missouri Health Facilities Review Committee				44 MoReg 1340 44 MoReg 1402 44 MoReg 1621
19 CSR 73-2.011	Missouri Board of Nursing Home Administrators	44 MoReg 1011	44 MoReg 1030		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Applied Behavior Analysis Maximum Benefit				44 MoReg 855
20 CSR	Caps for Medical Malpractice				43 MoReg 1376
20 CSR	Construction Claims Binding Arbitration Cap				43 MoReg 3869
20 CSR	Sovereign Immunity Limits				43 MoReg 3870
20 CSR	State Legal Expense Fund Cap				43 MoReg 3870
20 CSR 10-1.010	General Administration		44 MoReg 1143		
20 CSR 10-3.100	General Administration		44 MoReg 1145R		
20 CSR 10-3.200	General Administration		44 MoReg 1146R		
20 CSR 10-3.300	General Administration		44 MoReg 1146R		
20 CSR 10-3.900	General Administration		44 MoReg 688R	44 MoReg 1604R	
20 CSR 100-1.010	Insurer Conduct		44 MoReg 276	44 MoReg 1604	
20 CSR 100-1.030	Insurer Conduct		This Issue		
20 CSR 100-1.050	Insurer Conduct		44 MoReg 277	44 MoReg 1604	
20 CSR 100-1.070	Insurer Conduct		44 MoReg 278	44 MoReg 1604	
20 CSR 100-1.200	Insurer Conduct		44 MoReg 278R	44 MoReg 1604R	
20 CSR 100-1.300	Insurer Conduct		44 MoReg 279R	44 MoReg 1605R	
20 CSR 100-2.100	Insurer Conduct		44 MoReg 279R	44 MoReg 1605R	
20 CSR 100-3.100	Insurer Conduct		44 MoReg 279R	44 MoReg 1605R	
20 CSR 100-4.010	Insurer Conduct		44 MoReg 279R	44 MoReg 1605R	
20 CSR 100-4.020	Insurer Conduct		44 MoReg 280R	44 MoReg 1605R	
20 CSR 100-4.030	Insurer Conduct		44 MoReg 280R	44 MoReg 1605R	
20 CSR 100-4.100	Insurer Conduct		This Issue		
20 CSR 100-7.002	Insurer Conduct		44 MoReg 280	44 MoReg 1606	
20 CSR 100-7.005	Insurer Conduct		44 MoReg 281	44 MoReg 1606	
20 CSR 100-7.010	Insurer Conduct		44 MoReg 282R	44 MoReg 1606R	
20 CSR 100-8.002	Insurer Conduct		44 MoReg 282	44 MoReg 1606	
20 CSR 100-8.005	Insurer Conduct		44 MoReg 283	44 MoReg 1606	
20 CSR 100-8.008	Insurer Conduct		44 MoReg 284	44 MoReg 1607	
20 CSR 100-8.010	Insurer Conduct		44 MoReg 285R	44 MoReg 1607R	
20 CSR 100-8.012	Insurer Conduct		44 MoReg 285R	44 MoReg 1607R	
20 CSR 100-8.014	Insurer Conduct		44 MoReg 286	44 MoReg 1608	
20 CSR 100-8.015	Insurer Conduct		44 MoReg 286	44 MoReg 1608	
20 CSR 100-8.016	Insurer Conduct		This Issue		
20 CSR 100-8.018	Insurer Conduct		44 MoReg 287	44 MoReg 1608	
20 CSR 100-8.020	Insurer Conduct		44 MoReg 288R	44 MoReg 1608R	
20 CSR 100-8.040	Insurer Conduct		This Issue		
20 CSR 200-6.100	Insurance Solvency and Company Regulation		44 MoReg 689	44 MoReg 1608	
20 CSR 200-6.400	Insurance Solvency and Company Regulation		44 MoReg 689R	44 MoReg 1609R	
20 CSR 200-6.500	Insurance Solvency and Company Regulation		44 MoReg 689R	44 MoReg 1609R	
20 CSR 200-7.300	Insurance Solvency and Company Regulation		44 MoReg 690R	44 MoReg 1609R	
20 CSR 200-8.100	Insurance Solvency and Company Regulation		44 MoReg 1146		
20 CSR 200-9.500	Insurance Solvency and Company Regulation		44 MoReg 690	44 MoReg 1609	
20 CSR 200-9.600	Insurance Solvency and Company Regulation		44 MoReg 690	44 MoReg 1609	
20 CSR 200-9.700	Insurance Solvency and Company Regulation		44 MoReg 691	44 MoReg 1610	
20 CSR 200-9.800	Insurance Solvency and Company Regulation		44 MoReg 691	44 MoReg 1610	
20 CSR 200-10.100	Insurance Solvency and Company Regulation		44 MoReg 289	44 MoReg 1610	
20 CSR 200-10.300	Insurance Solvency and Company Regulation		44 MoReg 289	44 MoReg 1610	
20 CSR 200-10.400	Insurance Solvency and Company Regulation		44 MoReg 290	44 MoReg 1610	
20 CSR 200-10.500	Insurance Solvency and Company Regulation		44 MoReg 290	44 MoReg 1611	
20 CSR 200-11.120	Insurance Solvency and Company Regulation		44 MoReg 290	44 MoReg 1611	
20 CSR 200-11.130	Insurance Solvency and Company Regulation		44 MoReg 291	44 MoReg 1611	
20 CSR 200-11.150	Insurance Solvency and Company Regulation		44 MoReg 292	44 MoReg 1611	
20 CSR 200-11.300	Insurance Solvency and Company Regulation		44 MoReg 293R	44 MoReg 1611R	
20 CSR 200-12.030	Insurance Solvency and Company Regulation		44 MoReg 293	44 MoReg 1612	
20 CSR 200-13.100	Insurance Solvency and Company Regulation		44 MoReg 294	44 MoReg 1612	
20 CSR 200-13.200	Insurance Solvency and Company Regulation		44 MoReg 294	44 MoReg 1612	
20 CSR 200-13.300	Insurance Solvency and Company Regulation		44 MoReg 295R	44 MoReg 1612R	
20 CSR 200-14.200	Insurance Solvency and Company Regulation		44 MoReg 295	44 MoReg 1612	
20 CSR 200-14.300	Insurance Solvency and Company Regulation		44 MoReg 296R	44 MoReg 1613R	
20 CSR 200-14.400	Insurance Solvency and Company Regulation		44 MoReg 296R	44 MoReg 1613R	
20 CSR 200-16.010	Insurance Solvency and Company Regulation		44 MoReg 1149R		
20 CSR 200-16.020	Insurance Solvency and Company Regulation		44 MoReg 692R	44 MoReg 1613R	
20 CSR 200-16.030	Insurance Solvency and Company Regulation		44 MoReg 692R	44 MoReg 1613R	
20 CSR 200-16.040	Insurance Solvency and Company Regulation		44 MoReg 692R	44 MoReg 1613R	
20 CSR 200-16.050	Insurance Solvency and Company Regulation		44 MoReg 693R	44 MoReg 1614R	
20 CSR 200-16.060	Insurance Solvency and Company Regulation		44 MoReg 693R	44 MoReg 1614R	
20 CSR 200-16.070	Insurance Solvency and Company Regulation		44 MoReg 693R	44 MoReg 1614R	
20 CSR 200-16.080	Insurance Solvency and Company Regulation		44 MoReg 694R	44 MoReg 1614R	
20 CSR 200-16.090	Insurance Solvency and Company Regulation		44 MoReg 694R	44 MoReg 1614R	
20 CSR 200-16.100	Insurance Solvency and Company Regulation		44 MoReg 694R	44 MoReg 1615R	
20 CSR 200-16.110	Insurance Solvency and Company Regulation		44 MoReg 694R	44 MoReg 1615R	
20 CSR 200-16.120	Insurance Solvency and Company Regulation		44 MoReg 695R	44 MoReg 1615R	
20 CSR 200-16.130	Insurance Solvency and Company Regulation		44 MoReg 695R	44 MoReg 1615R	
20 CSR 200-17.100	Insurance Solvency and Company Regulation		This Issue		
20 CSR 200-17.300	Insurance Solvency and Company Regulation		This Issue		
20 CSR 200-18.010	Insurance Solvency and Company Regulation		44 MoReg 695	44 MoReg 1615	
20 CSR 200-18.020	Insurance Solvency and Company Regulation		44 MoReg 696	44 MoReg 1616	
20 CSR 200-18.110	Insurance Solvency and Company Regulation		44 MoReg 698	44 MoReg 1616	
20 CSR 200-18.120	Insurance Solvency and Company Regulation		44 MoReg 698	44 MoReg 1616	
20 CSR 200-20.040	Insurance Solvency and Company Regulation		This Issue		
20 CSR 200-21.300	Insurance Solvency and Company Regulation		44 MoReg 1149		
20 CSR 200-21.400	Insurance Solvency and Company Regulation		44 MoReg 1150		
20 CSR 200-21.500	Insurance Solvency and Company Regulation		44 MoReg 1152		
20 CSR 200-21.600	Insurance Solvency and Company Regulation		44 MoReg 1155		
20 CSR 400-2.040	Life, Annuities and Health		44 MoReg 700R	44 MoReg 1616R	
20 CSR 400-2.050	Life, Annuities and Health		44 MoReg 1155R		
20 CSR 400-2.070	Life, Annuities and Health		44 MoReg 1155R		
20 CSR 400-2.080	Life, Annuities and Health		44 MoReg 1155R		
20 CSR 400-2.100	Life, Annuities and Health		44 MoReg 1156R		
20 CSR 400-2.110	Life, Annuities and Health		44 MoReg 1156R		
20 CSR 400-2.120	Life, Annuities and Health		44 MoReg 1156R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 400-3.650	Life, Annuities and Health		This Issue		
20 CSR 400-5.300	Life, Annuities and Health		44 MoReg 1156R		
20 CSR 400-6.200	Life, Annuities and Health		44 MoReg 1157R		
20 CSR 400-6.300	Life, Annuities and Health		44 MoReg 1157R		
20 CSR 400-6.400	Life, Annuities and Health		44 MoReg 1157R		
20 CSR 400-6.600	Life, Annuities and Health		44 MoReg 1158R		
20 CSR 400-7.010	Life, Annuities and Health		44 MoReg 1158R		
20 CSR 400-7.060	Life, Annuities and Health		44 MoReg 1158R		
20 CSR 400-7.070	Life, Annuities and Health		44 MoReg 1158R		
20 CSR 400-7.080	Life, Annuities and Health		44 MoReg 1159R		
20 CSR 400-7.100	Life, Annuities and Health		44 MoReg 1159R		
20 CSR 400-7.110	Life, Annuities and Health		44 MoReg 1159R		
20 CSR 400-7.130	Life, Annuities and Health		44 MoReg 1159R		
20 CSR 400-7.150	Life, Annuities and Health		44 MoReg 1160R		
20 CSR 400-7.160	Life, Annuities and Health		44 MoReg 1160R		
20 CSR 400-7.170	Life, Annuities and Health		44 MoReg 1160R		
20 CSR 400-7.200	Life, Annuities and Health		44 MoReg 1161R		
20 CSR 400-7.300	Life, Annuities and Health		44 MoReg 1161R		
20 CSR 400-7.400	Life, Annuities and Health		44 MoReg 1161R		
20 CSR 400-8.100	Life, Annuities and Health		44 MoReg 1161R		
20 CSR 400-8.200	Life, Annuities and Health		44 MoReg 1162R		
20 CSR 400-8.300	Life, Annuities and Health		44 MoReg 1162R		
20 CSR 400-9.100	Life, Annuities and Health		44 MoReg 1162R		
20 CSR 400-14.100	Life, Annuities and Health		This Issue		
20 CSR 500-1.200	Property and Casualty		44 MoReg 296	44 MoReg 1617	
20 CSR 500-1.400	Property and Casualty		44 MoReg 297	44 MoReg 1617	
20 CSR 500-1.700	Property and Casualty		44 MoReg 297	44 MoReg 1617	
20 CSR 500-1.900	Property and Casualty		44 MoReg 298R	44 MoReg 1617R	
20 CSR 500-2.500	Property and Casualty		44 MoReg 298	44 MoReg 1617	
20 CSR 500-4.300	Property and Casualty		44 MoReg 299	44 MoReg 1618	
20 CSR 500-5.100	Property and Casualty		44 MoReg 701R	44 MoReg 1618R	
20 CSR 500-6.100	Property and Casualty		44 MoReg 1162		
20 CSR 500-6.300	Property and Casualty		44 MoReg 1163		
20 CSR 500-6.500	Property and Casualty		44 MoReg 1164		
20 CSR 500-6.700	Property and Casualty		44 MoReg 1165R		
20 CSR 600-1.010	Statistical Reporting		This Issue		
20 CSR 600-1.020	Statistical Reporting		44 MoReg 299	44 MoReg 1618	
20 CSR 600-2.100	Statistical Reporting		44 MoReg 300R	44 MoReg 1618R	
20 CSR 600-2.110	Statistical Reporting		44 MoReg 300	44 MoReg 1618	
20 CSR 600-2.120	Statistical Reporting		44 MoReg 301R	44 MoReg 1618R	
20 CSR 600-2.200	Statistical Reporting		44 MoReg 301	44 MoReg 1619	
20 CSR 600-2.300	Statistical Reporting		44 MoReg 303R	44 MoReg 1619R	
20 CSR 600-2.400	Statistical Reporting		44 MoReg 303	44 MoReg 1619	
20 CSR 600-2.500	Statistical Reporting		44 MoReg 304R	44 MoReg 1619R	
20 CSR 600-2.510	Statistical Reporting		44 MoReg 304	44 MoReg 1619	
20 CSR 600-2.600	Statistical Reporting		44 MoReg 304	44 MoReg 1619	
20 CSR 600-3.100	Statistical Reporting		This Issue		
20 CSR 700-1.005	Insurance Licensing		44 MoReg 1165		
20 CSR 700-1.025	Insurance Licensing		44 MoReg 1165		
20 CSR 700-1.040	Insurance Licensing		44 MoReg 1166R		
20 CSR 700-1.050	Insurance Licensing		44 MoReg 1166R		
20 CSR 700-1.070	Insurance Licensing		44 MoReg 1166		
20 CSR 700-1.160	Insurance Licensing		44 MoReg 1167		
20 CSR 700-1.170	Insurance Licensing		This Issue		
20 CSR 700-2.005	Insurance Licensing		44 MoReg 1168R		
20 CSR 700-2.100	Insurance Licensing		44 MoReg 1168R		
20 CSR 700-2.200	Insurance Licensing		44 MoReg 1168R		
20 CSR 700-2.300	Insurance Licensing		44 MoReg 1169R		
20 CSR 700-3.200	Insurance Licensing		44 MoReg 1169		
20 CSR 700-6.100	Insurance Licensing		44 MoReg 1170		
20 CSR 700-6.160	Insurance Licensing		44 MoReg 1171		
20 CSR 700-6.200	Insurance Licensing		44 MoReg 1172		
20 CSR 700-6.250	Insurance Licensing		44 MoReg 1173		
20 CSR 700-6.300	Insurance Licensing		44 MoReg 1173R		
20 CSR 2015-1.030	Acupuncturist Advisory Committee	44 MoReg 1011	44 MoReg 1030		
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 701	44 MoReg 1620	
20 CSR 2030-4.090	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1558		
20 CSR 2030-5.105	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1558		
20 CSR 2030-5.150	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1559		
20 CSR 2030-10.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		44 MoReg 1559		
20 CSR 2040-1.021	Office of Athletics		44 MoReg 820		
20 CSR 2040-2.011	Office of Athletics		44 MoReg 1033		
20 CSR 2040-2.021	Office of Athletics		44 MoReg 1033		
20 CSR 2040-3.011	Office of Athletics		44 MoReg 821		
20 CSR 2040-3.030	Office of Athletics		44 MoReg 822R		
20 CSR 2040-4.015	Office of Athletics		44 MoReg 822		
20 CSR 2040-4.020	Office of Athletics		44 MoReg 825		
20 CSR 2040-4.030	Office of Athletics		44 MoReg 825		
20 CSR 2040-4.040	Office of Athletics		44 MoReg 826		
20 CSR 2040-4.050	Office of Athletics		44 MoReg 826		
20 CSR 2040-4.060	Office of Athletics		44 MoReg 827R		
20 CSR 2040-4.070	Office of Athletics		44 MoReg 827		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2040-4.080	Office of Athletics		44 MoReg 827		
20 CSR 2040-4.090	Office of Athletics		44 MoReg 828		
20 CSR 2040-4.100	Office of Athletics		44 MoReg 832		
20 CSR 2040-5.010	Office of Athletics		44 MoReg 832R		
20 CSR 2040-5.040	Office of Athletics		44 MoReg 832		
20 CSR 2040-5.060	Office of Athletics		44 MoReg 833		
20 CSR 2040-5.070	Office of Athletics *(Changed from 20 CSR 2040-8.140)*		44 MoReg 840		
20 CSR 2040-6.010	Office of Athletics		44 MoReg 837		
20 CSR 2040-7.010	Office of Athletics		44 MoReg 837		
20 CSR 2040-8.010	Office of Athletics		44 MoReg 838R		
20 CSR 2040-8.020	Office of Athletics		44 MoReg 1036R		
20 CSR 2040-8.030	Office of Athletics		44 MoReg 1036R		
20 CSR 2040-8.040	Office of Athletics		44 MoReg 838R		
20 CSR 2040-8.050	Office of Athletics		44 MoReg 838R		
20 CSR 2040-8.060	Office of Athletics		44 MoReg 838R		
20 CSR 2040-8.070	Office of Athletics		44 MoReg 839R		
20 CSR 2040-8.080	Office of Athletics		44 MoReg 839R		
20 CSR 2040-8.090	Office of Athletics		44 MoReg 839R		
20 CSR 2040-8.100	Office of Athletics		44 MoReg 839R		
20 CSR 2040-8.110	Office of Athletics		44 MoReg 840R		
20 CSR 2040-8.120	Office of Athletics		44 MoReg 840R		
20 CSR 2040-8.130	Office of Athletics		44 MoReg 840R		
20 CSR 2040-8.140	Office of Athletics *(Changed to 20 CSR 2040-5.070)*		44 MoReg 840		
20 CSR 2040-8.160	Office of Athletics		44 MoReg 841		
20 CSR 2040-8.170	Office of Athletics		44 MoReg 842		
20 CSR 2040-8.180	Office of Athletics		44 MoReg 842		
20 CSR 2040-8.190	Office of Athletics		44 MoReg 842R		
20 CSR 2070-1.010	State Board of Chiropractic Examiners		44 MoReg 1305R		
20 CSR 2070-2.020	State Board of Chiropractic Examiners		44 MoReg 1305R		
20 CSR 2070-2.025	State Board of Chiropractic Examiners		44 MoReg 1305R		
20 CSR 2070-2.030	State Board of Chiropractic Examiners		44 MoReg 1305		
20 CSR 2070-2.031	State Board of Chiropractic Examiners		44 MoReg 1306R 44 MoReg 1306		
20 CSR 2070-2.032	State Board of Chiropractic Examiners		44 MoReg 1310		
20 CSR 2070-2.033	State Board of Chiropractic Examiners		44 MoReg 1310		
20 CSR 2070-2.040	State Board of Chiropractic Examiners		44 MoReg 1310R 44 MoReg 1311		
20 CSR 2070-2.045	State Board of Chiropractic Examiners		44 MoReg 1314R		
20 CSR 2070-2.050	State Board of Chiropractic Examiners		44 MoReg 1314R		
20 CSR 2070-2.065	State Board of Chiropractic Examiners		44 MoReg 1314		
20 CSR 2070-2.066	State Board of Chiropractic Examiners		44 MoReg 1315R		
20 CSR 2070-2.070	State Board of Chiropractic Examiners		44 MoReg 1315R		
20 CSR 2070-2.080	State Board of Chiropractic Examiners		44 MoReg 1316		
20 CSR 2070-2.081	State Board of Chiropractic Examiners		44 MoReg 1320		
20 CSR 2070-2.090	State Board of Chiropractic Examiners		44 MoReg 1324		
20 CSR 2070-2.100	State Board of Chiropractic Examiners		44 MoReg 1327		
20 CSR 2070-2.110	State Board of Chiropractic Examiners		44 MoReg 1327		
20 CSR 2110-2.001	Missouri Dental Board		44 MoReg 701	44 MoReg 1620	
20 CSR 2110-2.010	Missouri Dental Board		44 MoReg 1036		
20 CSR 2110-2.260	Missouri Dental Board		44 MoReg 572R	44 MoReg 1395R	
20 CSR 2117-1.010	Office of Statewide Electrical Contractors		44 MoReg 305	44 MoReg 1395	
20 CSR 2117-1.020	Office of Statewide Electrical Contractors		44 MoReg 308	44 MoReg 1396	
20 CSR 2117-1.030	Office of Statewide Electrical Contractors		44 MoReg 311	44 MoReg 1396	
20 CSR 2117-1.040	Office of Statewide Electrical Contractors		44 MoReg 314	44 MoReg 1396	
20 CSR 2117-1.050	Office of Statewide Electrical Contractors		44 MoReg 317	44 MoReg 1396	
20 CSR 2117-1.060	Office of Statewide Electrical Contractors		44 MoReg 320	44 MoReg 1397	
20 CSR 2117-1.070	Office of Statewide Electrical Contractors		44 MoReg 323	44 MoReg 1397	
20 CSR 2117-2.010	Office of Statewide Electrical Contractors		44 MoReg 328	44 MoReg 1397	
20 CSR 2117-2.020	Office of Statewide Electrical Contractors		44 MoReg 333	44 MoReg 1398	
20 CSR 2117-2.030	Office of Statewide Electrical Contractors		44 MoReg 337	44 MoReg 1398	
20 CSR 2117-2.040	Office of Statewide Electrical Contractors		44 MoReg 341	44 MoReg 1398	
20 CSR 2117-2.050	Office of Statewide Electrical Contractors		44 MoReg 345	44 MoReg 1398	
20 CSR 2117-2.060	Office of Statewide Electrical Contractors		44 MoReg 350	44 MoReg 1399	
20 CSR 2117-2.070	Office of Statewide Electrical Contractors		44 MoReg 353	44 MoReg 1399	
20 CSR 2117-2.080	Office of Statewide Electrical Contractors		44 MoReg 356	44 MoReg 1399	
20 CSR 2117-3.010	Office of Statewide Electrical Contractors		44 MoReg 361	44 MoReg 1399	
20 CSR 2117-3.020	Office of Statewide Electrical Contractors		44 MoReg 364	44 MoReg 1399	
20 CSR 2117-3.030	Office of Statewide Electrical Contractors		44 MoReg 367	44 MoReg 1400	
20 CSR 2117-4.010	Office of Statewide Electrical Contractors		44 MoReg 370	44 MoReg 1400	
20 CSR 2117-5.010	Office of Statewide Electrical Contractors		44 MoReg 373	44 MoReg 1400	
20 CSR 2150-2.080	State Board of Registration for the Healing Arts	44 MoReg 1012	44 MoReg 1037		
20 CSR 2150-2.200	State Board of Registration for the Healing Arts		44 MoReg 1174		
20 CSR 2150-2.230	State Board of Registration for the Healing Arts	44 MoReg 1013	44 MoReg 1040		
20 CSR 2150-2.240	State Board of Registration for the Healing Arts	44 MoReg 1013	44 MoReg 1040		
20 CSR 2150-2.250	State Board of Registration for the Healing Arts	44 MoReg 1015	44 MoReg 1041		
20 CSR 2150-2.260	State Board of Registration for the Healing Arts	44 MoReg 1016	44 MoReg 1042		
20 CSR 2150-5.100	State Board of Registration for the Healing Arts	44 MoReg 27T 44 MoReg 1016	44 MoReg 1042		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2150-7.130	State Board of Registration for the Healing Arts	44 MoReg 1018	44 MoReg 1044		
20 CSR 2150-7.135	State Board of Registration for the Healing Arts	44 MoReg 1018	44 MoReg 1044		
20 CSR 2165-1.020	Board of Examiners for Hearing Instrument Specialists		44 MoReg 1175		
20 CSR 2193-1.010	Interior Design Council		44 MoReg 1178		
20 CSR 2193-2.010	Interior Design Council		44 MoReg 1178		
20 CSR 2193-2.020	Interior Design Council		44 MoReg 1178		
20 CSR 2193-2.030	Interior Design Council		44 MoReg 1179		
20 CSR 2193-2.040	Interior Design Council		44 MoReg 1179		
20 CSR 2193-3.010	Interior Design Council		44 MoReg 1180R		
20 CSR 2193-3.020	Interior Design Council		44 MoReg 1180		
20 CSR 2193-4.010	Interior Design Council		44 MoReg 1181		
20 CSR 2193-5.010	Interior Design Council		44 MoReg 1181		
20 CSR 2193-6.010	Interior Design Council		44 MoReg 1182		
20 CSR 2193-6.030	Interior Design Council		44 MoReg 1182R		
20 CSR 2200-4.010	State Board of Nursing		44 MoReg 843		
20 CSR 2200-4.200	State Board of Nursing	44 MoReg 27T 44 MoReg 1020	44 MoReg 1045		
20 CSR 2220-2.016	State Board of Pharmacy		This Issue		
20 CSR 2220-2.050	State Board of Pharmacy		This Issue		
20 CSR 2220-2.060	State Board of Pharmacy		This Issue		
20 CSR 2220-2.080	State Board of Pharmacy		This Issue		
20 CSR 2220-2.120	State Board of Pharmacy		44 MoReg 1388		
20 CSR 2220-2.150	State Board of Pharmacy		This Issue		
20 CSR 2220-2.180	State Board of Pharmacy		This Issue		
20 CSR 2220-2.300	State Board of Pharmacy		This Issue		
20 CSR 2220-2.400	State Board of Pharmacy	44 MoReg 1241	44 MoReg 1331		
20 CSR 2220-2.500	State Board of Pharmacy		44 MoReg 1560		
20 CSR 2220-2.600	State Board of Pharmacy		This Issue		
20 CSR 2220-2.800	State Board of Pharmacy		This Issue		
20 CSR 2220-3.011	State Board of Pharmacy		44 MoReg 1389		
20 CSR 2220-6.030	State Board of Pharmacy		This IssueR		
20 CSR 2220-7.080	State Board of Pharmacy		This Issue		
20 CSR 2220-8.040	State Board of Pharmacy	44 MoReg 31	44 MoReg 115	44 MoReg 1339	
20 CSR 2230-1.010	State Board of Podiatric Medicine		This Issue		
20 CSR 2231-1.010	State Board of Pharmacy		44 MoReg 702	This Issue	
20 CSR 2231-2.010	State Board of Pharmacy		44 MoReg 702	This Issue	
20 CSR 2233-1.040	State Committee of Marital and Family Therapists		44 MoReg 1565		
20 CSR 2245-5.020	Real Estate Appraisers		44 MoReg 119	44 MoReg 1339	
20 CSR 2245-6.015	Real Estate Appraisers		44 MoReg 951R		
20 CSR 2245-6.017	Real Estate Appraisers		44 MoReg 951		
20 CSR 2263-1.010	State Committee for Social Workers		44 MoReg 956		
20 CSR 2263-1.016	State Committee for Social Workers		44 MoReg 956		
20 CSR 2263-1.025	State Committee for Social Workers		44 MoReg 956		
20 CSR 2263-2.020	State Committee for Social Workers		44 MoReg 1046R		
20 CSR 2263-2.030	State Committee for Social Workers		44 MoReg 1047		
20 CSR 2263-2.031	State Committee for Social Workers		44 MoReg 1182		
20 CSR 2263-2.032	State Committee for Social Workers		44 MoReg 1047		
20 CSR 2263-2.050	State Committee for Social Workers		44 MoReg 1047		
20 CSR 2263-2.060	State Committee for Social Workers		44 MoReg 1048		
20 CSR 2263-2.075	State Committee for Social Workers		44 MoReg 1048		
20 CSR 2263-2.090	State Committee for Social Workers		44 MoReg 1049		
20 CSR 2263-3.100	State Committee for Social Workers		44 MoReg 1049		
20 CSR 2270-4.031	Missouri Veterinary Medical Board	44 MoReg 1242	44 MoReg 1331		

Agency		Publication	Effective	Expiration
Department of Economic Development				
Division of Business and Community Services				
4 CSR 85-5.010	Overview and Definitions	44 MoReg 1229	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.020	Applications	44 MoReg 1230	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.030	Preliminary Application Evaluation- Net Fiscal Benefit	44 MoReg 1232	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.040	Preliminary Application- Overall Size and Quality of the Project	44 MoReg 1233	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.050	Preliminary Application- Level of Economic Distress	44 MoReg 1233	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.060	Preliminary Application- Input from Local Elected Officials	44 MoReg 1234	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.070	Compliance with Other Provisions of Law	44 MoReg 1234	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.080	Phased Projects	44 MoReg 1235	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.090	Developer Fees; General Contractor Requirements	44 MoReg 1235	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.100	Not-for-Profits	44 MoReg 1236	March 30, 2019	Dec. 31, 2019
4 CSR 85-5.110	Administrative Closure	44 MoReg 1237	March 30, 2019	Dec. 31, 2019
Public Service Commission				
4 CSR 240-40.033	Safety Standards - Liquefied Natural Gas Facilities	44 MoReg 493	Dec. 29, 2018	June 26, 2019
Department of Mental Health				
Certification Standards				
9 CSR 30-6.010	Certified Community Behavioral Health Clinics	44 MoReg 1237	July 1, 2019	Oct. 30, 2019
Department of Revenue				
Director of Revenue				
12 CSR 10-2.015	Employers' Withholding of Tax	44 MoReg 1493	April 26, 2019	Feb. 5, 2020
12 CSR 10-41.010	Annual Adjusted Rate of Interest	43 MoReg 3347	Jan. 1, 2019	June 29, 2019
Department of Social Services				
MO HealthNet Division				
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates	44 MoReg 494	Dec. 31, 2018	Term May 31, 2019
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates	This Issue	June. 1, 2019	Dec. 30, 2019
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	This Issue	June. 1, 2019	Dec. 30, 2019
Elected Officials				
Secretary of State				
15 CSR 30-14.010	Campaign Contribution Limits	44 MoReg 1241	March 30, 2019	Jan. 8, 2020
15 CSR 30-200.025	Application and Payment Procedures for Appropriations or Grants	44 MoReg 897	Feb. 17, 2019	Aug. 15, 2019
Department of Health and Senior Services				
Office of the Director				
19 CSR 20-60.010	Levels of Maternal and Neonatal Care Designations	44 MoReg 496	Dec. 30, 2018	June 27, 2019
19 CSR 30-20.013	Incorporation of Medicare Conditions of Participation	44 MoReg 897	Feb. 24, 2019	Aug. 22, 2019
19 CSR 30-60.020	Application for Annual Fire Safety and Health and Sanitation Inspections and Inspection Procedures	44 MoReg 898	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-60.050	Staffing Requirements	44 MoReg 899	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-61.025	Organization and Administration	44 MoReg 900	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-61.045	Initial Licensing Information	44 MoReg 901	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-61.055	License Renewal	44 MoReg 901	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-61.105	The Day Care Provider and Other Day Care Personnel	44 MoReg 903	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-61.210	Records and Reports	44 MoReg 904	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-62.032	Organization and Administration	44 MoReg 905	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-62.042	Initial Licensing Information	44 MoReg 905	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-62.052	License Renewal	44 MoReg 906	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-62.102	Personnel	44 MoReg 907	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-62.222	Records and Reports	44 MoReg 909	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-63.010	Definitions	44 MoReg 910	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-63.020	General Requirements	44 MoReg 911	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-63.030	Criminal Background Screening Cost	44 MoReg 911	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-63.040	Background Screening Findings	44 MoReg 912	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-63.050	Process for Appeal Required in Section 210.1080, RSMo	44 MoReg 913	Feb. 25, 2019	Aug. 23, 2019
19 CSR 30-95.010	Definitions	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.020	General Provisions	44 MoReg 271	Dec. 24, 2018	June 21, 2019
19 CSR 30-95.025	Generally Applicable Provisions	Next Issue	June 3, 2019	Feb. 27, 2020

Agency		Publication	Effective	Expiration
19 CSR 30-95.030	Qualifying Patient/Primary Caregiver	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.040	Medical Marijuana Facilities Generally	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.050	Cultivation Facility	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.060	Infused Products Manufacturing Facility	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.070	Testing Facility	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.080	Dispensary Facility	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.090	Seed to Sale Tracking	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.100	Transportation	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 30-95.110	Physicians	Next Issue	June 3, 2019	Feb. 27, 2020
19 CSR 73-2.011	Fee Waiver for Military Families and Low-Income Individuals	44 MoReg 1011	March 3, 2019	Aug. 29, 2019
Department of Insurance, Financial Institutions and Professional Registration				
Acupuncturist Advisory Committee				
20 CSR 2015-1.030	Fees	44 MoReg 1011	April 1, 2019	Sept. 30, 2019
State Board of Registration for the Healing Arts				
20 CSR 2150-2.080	Physician Licensure Fees	44 MoReg 1012	March 4, 2019	Aug. 30, 2019
20 CSR 2150-2.230	Assistant Physician—Continuing Education	44 MoReg 1013	March 4, 2019	Aug. 30, 2019
20 CSR 2150-2.240	Assistant Physician Collaborative Practice Agreements	44 MoReg 1013	March 4, 2019	Aug. 30, 2019
20 CSR 2150-2.250	Assistant Physician—Collaborative Practice Change Requirements	44 MoReg 1015	March 4, 2019	Aug. 30, 2019
20 CSR 2150-2.260	Assistant Physician—Certificate of Prescriptive Authority	44 MoReg 1016	March 4, 2019	Aug. 30, 2019
20 CSR 2150-5.100	Collaborative Practice Arrangement with Nurses	44 MoReg 1016	March 4, 2019	Aug. 30, 2019
20 CSR 2150-7.130	Applicants for Certificate of Controlled Substance Prescriptive Authority	44 MoReg 1018	March 4, 2019	Aug. 30, 2019
20 CSR 2150-7.135	Physician Assistant Supervision Agreements	44 MoReg 1018	March 4, 2019	Aug. 30, 2019
State Board of Nursing				
20 CSR 2200-4.200	Collaborative Practice	44 MoReg 1020	March 4, 2019	Aug. 30, 2019
State Board of Pharmacy				
20 CSR 2220-2.400	Compounding Standards of Practice	44 MoReg 1241	March 30, 2019	Jan. 8, 2020
Missouri Veterinary Medical Board				
20 CSR 2270-4.031	Minimum Standards for Practice Techniques	44 MoReg 1242	March 30, 2019	Jan. 8, 2020
Missouri Consolidated Health Care Plan				
22 CSR 10-1.030	Board of Trustees Election Process	43 MoReg 3354	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.010	Definitions	43 MoReg 3356	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.020	General Membership Provisions	43 MoReg 3357	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.030	Contributions	43 MoReg 3362	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.045	Plan Utilization Review Policy	43 MoReg 3365	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.046	PPO 750 Plan Benefit Provisions and Covered Charges	43 MoReg 3366	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.047	PPO 1250 Plan Benefit Provisions and Covered Charges	43 MoReg 3368	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	43 MoReg 3370	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	43 MoReg 3370	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.053	Health Savings Account Plan Benefit Provisions and Covered Charges	43 MoReg 3370	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	43 MoReg 3372	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.060	PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations	43 MoReg 3381	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.061	Plan Limitations	43 MoReg 3382	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.075	Review and Appeals Procedure	43 MoReg 3383	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.080	Miscellaneous Provisions	43 MoReg 3384	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.088	Medicare Advantage Plan	43 MoReg 3384	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	43 MoReg 3385	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.090	Pharmacy Benefit Summary	43 MoReg 3386	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.110	General Foster Parent Membership Provisions	43 MoReg 3389	Jan. 1, 2019	June 29, 2019
22 CSR 10-2.140	Strive for Wellness® Health Center Provisions, Charges, and Services	43 MoReg 3390	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.010	Definitions	43 MoReg 3391	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.020	General Membership Provisions	43 MoReg 3392	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.045	Plan Utilization Review Policy	43 MoReg 3395	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	43 MoReg 3396	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.055	Health Savings Account Plan Benefit Provisions and Covered Charges	43 MoReg 3397	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.056	PPO 600 Plan Benefit Provisions and Covered Charges	43 MoReg 3397	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	43 MoReg 3398	Jan. 1, 2019	June 29, 2019

Agency	Publication	Effective	Expiration
22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges	43 MoReg 3407	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges	43 MoReg 3409	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations	43 MoReg 3410	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.061 Plan Limitations	43 MoReg 3411	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.080 Miscellaneous Provisions	43 MoReg 3412	Jan. 1, 2019	June 29, 2019
22 CSR 10-3.090 Pharmacy Benefit Summary	43 MoReg 3413	Jan. 1, 2019	June 29, 2019

Executive Orders	Subject Matter	Filed Date	Publication
	2019		
19-09	Calls and orders into active service, portions of the organized militia as necessary to aid executive officials in protecting life and property	May 27, 2019	Next Issue
19-08	Declares a State of Emergency	May 21, 2019	Next Issue
Writ of Election	Fills vacancy in the One Hundredth General Assembly from the 158th district	April 23, 2019	44 MoReg 1499
Writ of Election	Fills vacancy in the One Hundredth General Assembly from the 99th district	April 23, 2019	44 MoReg 1497
19-07	Extends Executive Order 19-06 - State of Emergency	April 30, 2019	44 MoReg 1501
19-06	Gives the Department of Natural Resources discretionary authority to waive or suspend operation to best serve the interests of the public health and safety during the State of Emergency	March 29, 2019	44 MoReg 1246
19-05	Declares a State of Emergency	March 21, 2019	44 MoReg 1244
19-04	Establishes the Missouri School Safety Task Force	March 13, 2019	44 MoReg 1131
Proclamation	Governor reduces line items in the budget.	Jan. 28, 2019	44 MoReg 771
19-03	Transfers the Division of Workforce Development to the Department of Higher Education	Jan. 17, 2019	44 MoReg 767
19-02	Transfers the Office of Public Counsel and Public Service Commission to the Department of Insurance, Financial Institutions and Professional Registration	Jan. 17, 2019	44 MoReg 765
19-01	Transfers the Division of Energy to the Department of Natural Resources	Jan. 17, 2019	44 MoReg 763
	2018		
18-12	Establishes the Missouri 2020 Complete Count Committee	Dec. 18, 2018	44 MoReg 498
18-11	Closes state offices December 24, 2018.	Nov. 30, 2018	43 MoReg 3761
18-10	Establishes that each executive branch adhere to the code of conduct regarding gifts form lobbyist	Nov. 20, 2018	44 MoReg 36
18-09	Closes state offices November 23, 2018.	Nov. 1, 2018	43 MoReg 3204
18-08	Establishes the Missouri Justice Reinvestment Executive Oversight Council.	Oct. 25, 2018	43 MoReg 3472
Proclamation	Governor temporarily reduces line items in the budget.	Oct. 31, 2018	43 MoReg 3416
18-07	Establishes the Bicentennial Commission.	Oct. 12, 2018	43 MoReg 3202
Proclamation	Calls upon the Senators and Representatives to enact legislation requiring the Department of Elementary and Secondary Education to establish a statewide program to be known as the "STEM Career Awareness Program."	Sept. 4, 2018	43 MoReg 2780
18-06	Designates those members of the governor's staff who have supervisory authority over each department, division, or agency of state government.	Aug. 21, 2018	43 MoReg 2778
18-05	Declares a drought alert for 47 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	July 18, 2018	43 MoReg 2539
18-04	Extends the deadline from Section 3d of Executive Order 17-03 through September 30,2018.	June 29, 2018	43 MoReg 1996
18-03	Reauthorizes and restructures the Homeland Security Advisory Council.	April 25, 2018	43 MoReg 1123
18-02	Declares a State of Emergency and activates the state militia in response to severe weather that began on Feb. 23.	Feb. 24, 2018	43 MoReg 664
Proclamation	Governor notifies the General Assembly that he is reducing appropriation lines in the fiscal year 2018 budget.	Feb. 14, 2018	43 MoReg 519
18-01	Rescinds Executive Order 07-21.	Jan. 4, 2018	43 MoReg 251

The rule number and the MoReg publication date follow each entry to this index.

Rulemaking Classes

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